PUBLIC HEALTH NURSING

OCTOBER
1949

Effective, Convenient, Economical

THE effectiveness of Mercurochrome has been demonstrated by more than twenty years of extensive clinical use. For professional convenience Mercurochrome is supplied in four forms—Aqueous Solution in Applicator Bottles for the treatment of minor wounds, Surgical Solutions for preoperative skin disinfection, Tablets and Powder from which solutions of any desired concentration may readily be prepared.

Mercurochrome

(H. W. & D. brand of merbromin, dibromoxymercurifluorescein-sodium)

is economical because stock solutions may be dispensed quickly and at low cost. Stock solutions keep indefinitely.

Mercurochrome is antiseptic and relatively non-irritating and non-toxic in wounds.

Complete literature will be furnished on request.

HYNSON, WESTCOTT & DUNNING, INC.

Baltimore, Maryland

Press of Thomas J. Griffiths Sons, Inc., Utica, N. Y.

PUBLIC HEALTH NURSING

VOL. 41, No. 10 OCTOBER 1949

CONTENTS

PUBLIC HEALTH NURSING

Editor: MARY EDWARDS SHAW *Assistant Editor:* HEDWIG COHEN, R.N.

 Published monthly. Entered as second class matter April 1, 1932 at the Post Office at Utica, New York, under the Act of March 3, 1879. Acceptance for mailing at special rate of postage as provided for in Section 1103, Act of October 3, 1917 authorized August 27, 1918.

Subscription rates of PUBLIC HEALTH NURSING for United States and possessions, the Americas and Mexico, are $4.00 per 1 year and $6.50 per 2 years (subscription rate to NOPHN members, 1 year $3.00). Foreign and Canadian add 50 cents per year. Single copies 45 cents. Rate in combination with *American Journal of Nursing*, $6.50 per 1 year. Rate in combination with *The Survey*, $7.75.

Cromwell on Health of the School Child

Miss Cromwell writes with discernment on the problems facing not only the specialized school nurse but also the general public health nurse who serves the school. A detailed discussion is given on the Findings of the School Medical Appraisal which covers record keeping and proper steps in follow-up with parent and teacher.

By GERTRUDE E. CROMWELL, R.N., M.S., Supervisor of Public School Nursing, Denver, Colorado. 356 pages, illustrated. $3.00

Miller and Hyde's Gynecology and Gynecologic Nursing

New (2nd) Edition—Nursing care of the diseases of women is described here so that the reason—as well as each step—is easy to follow. 5 new chapters were added for this edition and new material inserted throughout. The 240 illustrations in this book are outstanding and stress those points which are of particular value in gynecologic nursing care.

By NORMAN F. MILLER, M.D., Professor of Obstetrics and Gynecology, University of Michigan Medical School; and **BETTY HYDE, R.N.,** Supervisor of the Gynecology Wards, University of Michigan Hospital. 474 pages, with 240 illustrations. $4.25

Bookmiller and Bowen's Obstetrics and Obstetric Nursing

The authors of this important textbook give the nurse a graphic picture of just how she is expected to help the prospective mother every step of the way—from early in pregnancy until she has learned to care properly for her newborn child. The economic and social aspects are kept in mind at all times. Labor and delivery in both the hospital and home are covered.

By MAE M. BOOKMILLER, R.N., Instructor in Obstetric Nursing, New York University College of Medicine; Supervisor in Obstetrics, Division of Nursing, Bellevue Hospital; and **GEORGE L. BOWEN, M.D.,** Associate Clinical Professor of Obstetrics and Gynecology, New York University College of Medicine; Associate Visiting Obstetrician and Gynecologist, Bellevue Hospital. 737 pages, 350 illustrations. $4.50

W. B. Saunders COMPANY

West Washington Square **Philadelphia 5**

NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

1790 Broadway, New York 19, N. Y.

ADVISORY COUNCIL

C.-E. A. Winslow, Dr.P.H., Chairman...New Haven, Conn.
Donald B. Armstrong, M.D.....New York, N. Y.
Margaret Culkin Banning.....Duluth, Minn.
Mrs. August Belmont.....New York, N. Y.
Mrs. Chester C. Bolton.....Washington, D.C.
Kendall Emerson, M.D.....New York, N. Y.
Lillian M. Gilbreth, Dr. Eng.....Lafayette, Ind.
Thomas Parran, M.D.....Pittsburgh, Pa.
Rev. Alphonse M. Schwitalla, S.J.....St. Louis, Mo.
Rabbi Abba Hillel Silver, D.D.....Cleveland, O.
William F. Snow, M.D.....New York, N. Y.
Lucy Ward Stebbins.....Berkeley, Calif.
John W. Studebaker, LL.D.....New York, N. Y.
Henry F. Vaughan, Dr.P.H.....Ann Arbor, Mich.

BOARD OF DIRECTORS

Mary S. Gardner, R.N., Honorary President
Providence, R. I.
*Ruth W. Hubbard, R.N., President.....Philadelphia, Pa.
*Ruth B. Freeman, R.N., 1st V. P.....Washington, D.C.
*Mrs. Carl B. Grawn, 2nd V. P.....Grosse Pointe, Mich.
*L. Meredith Maxson, Treas.....New York, N. Y.
*Anna Fillmore, R.N., Sec'y.....New York, N. Y.
Elin L. Anderson.....Washington, D.C.
Mrs. C. Welles Belin.....Waverly, Pa.
Mrs. Lloyd D. Brace.....Charles River, Mass.
Amos Christie, M.D.....Nashville, Tenn.
Mrs. William Bell Cook.....Seattle, Wash.
Mrs. Pearl Parvin Coulter, R.N.....Boulder, Colo.
*Mrs. Gammell Cross.....Providence, R. I.
Albert W. Dent.....New Orleans, La.
Mrs. Carroll J. Dickson.....Brooklyn, N. Y.
Mary M. Dunlap, R.N.....Chicago, Ill.
Theodora A. Floyd, R.N.....Atlanta, Ga.
Ruth A. Heintzelman, R.N.....Washington, D.C.
Hortense Hilbert, R.N.....New York, N. Y.
Ira V. Hiscock, Sc.D.....New Haven, Conn.
Mrs. H. Stanley Johnson.....Madison, Wis.
*Marie L. Johnson, R.N.....New York, N. Y.
*Mrs. Olive W. Klump, R.N.....Los Angeles, Calif.
Mrs. Montgomery S. Lewis.....Indianapolis, Ind.
Mrs. L. C. Parks.....Pensacola, Fla.
*Donna Pearce, R.N.....Richmond, Va.
Mrs. John R. Schermer.....Grand Rapids, Mich.
*Marion W. Sheahan, R.N.....New York, N. Y.
*Mrs. Donald C. Shepard.....Neenah, Wis.
*Nathan Sinai, Dr.P.H.....Ann Arbor, Mich.
Margaret S. Taylor, R.N.....Minneapolis, Minn.
*Ralph Chester Williams, M.D.....Washington, D.C.

*Member of the Executive Committee.

MAGAZINE COMMITTEE

Margaret Shetland, R.N., Chairman.....Lansing, Mich.
Martha Adam, R.N.....San Mateo, Calif.
Dorothy M. Allen, R.N.....Brattleboro, Vermont
Lillian M. Bischoff, R.N.....Atlanta, Ga.
Mrs. Latis M. Campbell, R.N.....New York, N. Y.
Caroline Falls, R.N.....New York, N. Y.
Roberta Foote, R.N.....Topeka, Kansas
Agnes L. Fuller, R.N.....New York, N. Y.
Emogean Guthrie, R.N.....Spartanburg, S. C.
Lily Hagerman, R.N.....Juneau, Alaska
Josephine Hawes, R.N.....New York, N. Y.
Elizabeth Hoeltzel, R.N.....Little Rock, Ark.
Isabelle Jordan, R.N.....Washington, D.C.
Dorothy Kelly, R.N.....Detroit, Mich.
Evelyn Kidneigh, R.N.....Salt Lake City, Utah
Grace Larsen, R.N.....Greeley, Colo.
Faye Pannell, R.N.....Dallas, Texas
Elizabeth Reed, R.N.....Jacksonville, Fla.
Alice Rohrbaugh, R.N.....Seattle, Wash.
Clara B. Rue, R.N.....Milwaukee, Wisc.
Ruth Scott, R.N.....Fort Wayne, Ind.
Theodora Sharrocks, R.N.....Yonkers, N. Y.
Eugene R. Spaulding.....New York, N. Y.
Helena Tepper, R.N.....San Jose, Calif.

STAFF

Anna Fillmore, R.N.....General Director
Ruth Fisher, R.N.....Associate Director
Lillian Christensen.....Assistant Director
Hedwig Cohen, R.N.....Assistant Director
M. Olwen Davies, R.N.....Assistant Director
Helen Nelson.....Assistant Director
Dorothy Rusby, R.N.....Assistant Director
Marie Swanson, R.N.....Assistant Director
Elizabeth C. Stobo, R.N.....Director of Cost Study
Dorothy E. Wiesner.....Statistician
Mary E. Shaw.....Editor

Services conducted jointly with other organizations:
Joint Orthopedic Nursing Advisory Service.....Louise M. Suchomel, R.N., Lucy E. Blair, R.N., and Marion P. Kerr, R.N.
Joint Tuberculosis Nursing Advisory Service.....Jean South, R.N.

The National Organization for Public Health Nursing is a membership organization composed of individual and agency members. Its purpose is to serve as a clearing house of information, and to develop and interpret standards for personnel and practices in public health nursing. This is accomplished through an advisory service to individuals and agencies interested in public health nursing; through publications, including the official magazine, PUBLIC HEALTH NURSING, and through connections with national, state, and local agencies in related fields. The organization is administered by an elected board of lay and professional members. Its activities are carried on by committees representing public health nursing and related fields, and by an employed staff.

The organization has no jurisdiction over its membership. It serves in a purely advisory capacity. The acceptance of any of its recommendations is entirely voluntary.

Membership—Nurse, $5; General, $5; Sustaining, $10; Life, $100. Agency—Full dues 1% of annual expenditures for public health nursing service. Associate agency, $10.

HOPKINS NORTHN STYLE UNIFORMS

THE

BERET

Smartly styled to tilt at any angle. In small, medium or large head sizes. Your choice of fabric—

Navy Blue Elastique.....$4.50
Navy Blue Whipcord.....$4.50
Blue and white striped Seersucker....$2.25

THE

OVERSEAS CAP

The universally popular Public Health Nurses cap. Head conforming. Small, medium or large.

Your choice of fabric—
Navy Blue Elastique.....$3.50
Navy Blue Whipcord.....$3.50
Blue and white striped Seersucker....$1.75

THE

NAVY SWEATER

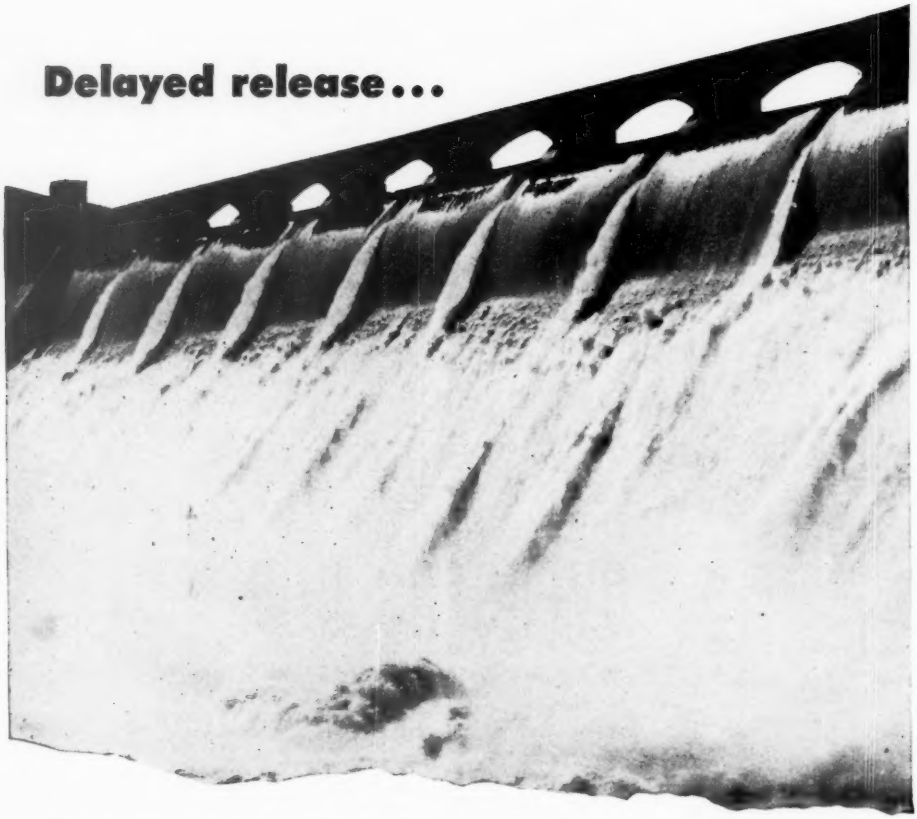
Lovely, soft sweater of 100% pure Australian Zephyr wool. (Sanforlan Shrink proof). It is beautifully hand fashioned and hand finished with Nylon ribbon trim and ocean pearl buttons. Sizes 34 thru 44.

$7.95

HOPKINS TAILORING CO. 107 W. FAYETTE ST., BALTIMORE 1, MD.

In responding to an advertisement say you saw it in Public Health Nursing

Delayed release...



Just as a great dam stores and releases water only as fast as the fertile lands below can utilize it, so does Alhydrox* adsorb antigens and release them *slowly* from tissue after injection. This gives the effect of continuous small doses.

Alhydrox is a Cutter exclusive—developed and used by Cutter for its vaccines and toxoids. It supplements the physician's skill by producing these immunizing advantages:

1. *Alhydrox selectivity controls the absorption of antigens, reducing dosage volume while building a high antibody concentration.*

2. *Alhydrox, because of its favorable pH, lessens pain on injection and reduces side reactions to a minimum.*

3. *Alhydrox adsorbed antigens are released slowly from tissue, giving the effect of small repeated doses.*

* *Trade name for Aluminum Hydroxide Adsorbed*

Specify these Cutter ***Alhydrox*** *Vaccines:*

- **Pertussis Phase I Alhydrox**
  30,000 million H pertussis per cc.
- **Tetanus Toxoid Alhydrox**
- **Diphtheria Toxoid Alhydrox**
- **Diptussis Alhydrox®**
  Cutter Diphtheria Toxoid plus 20,000 million H pertussis per cc. for simultaneous immunization against pertussis and diphtheria
- **Diphtheria Toxoid-Tetanus Toxoid Alhydrox**
  For simultaneous immunization against diphtheria and tetanus
- **Dip-Pert-Tet Alhydrox****
  Cutter diphtheria, pertussis, tetanus combined vaccine for simultaneous immunization against diphtheria, pertussis, tetanus

** *Trade Mark*

Your Cutter dealer has ***Alhydrox*** *vaccines in stock*

Alhydrox is exclusive with CUTTER

CUTTER LABORATORIES • BERKELEY 10, CALIF.

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

CLASSIFYING NURSING EDUCATION

IN A SHORT TIME the Interim Classification of Schools of Nursing Offering Basic Programs (1949) will be published. The story of the survey which resulted in the Interim Classification appears on page 546. The Classification is an undertaking of the Subcommittee on School Data Analysis which was appointed by the National Committee for the Improvement of Nursing Services in December 1948.

The Interim Classification marks a first in nursing history. Previous gradings of schools of nursing have been made but no published lists have resulted, although the individual schools were informed of their standings. The Classification is established from data compiled by the institutions and sent in answer to a questionnaire prepared by the subcommittee. The schools were rated in comparison with each other concerning actual practices as reported for a set date, February 1949. The bases selected as criteria for comparison of practices appear sound and valid. There are certain limitations in this type of survey but it must be remembered it was not intended to be a comprehensive study as detailed evaluation procedures were not applied. The first grouping of 25 percent of the schools includes those which rated highest in the questionnaire. The second grouping is of the middle 50 percent of the schools. The remaining 25 percent are not listed. These include those schools that fell into the lowest quartile, those which did not participate in the study, and those which chose for various reasons, not to be included in the published list. The Interim Classification itself will be published in an early issue of the *American Journal of Nursing*, and reprints will be available.

Nurses must be sure they know and can interpret to others the difference between the Interim Classification and the List of Accredited Educational Programs in Nursing for 1949. The list of accredited educational programs combines the approved lists of the National Organization for Public Health Nursing, the National League for Nursing Education, the Association of Collegiate Schools of Nursing, and the Conference of Catholic Schools of Nursing. This first combined list is published by the National Nursing Accrediting Service sponsored by the Committee of the Six National Nursing Organizations on Unification of Accrediting Activities and will appear in the *AJN* October 1949. For the names of institutions with programs approved for public health nursing see also PUBLIC HEALTH NURSING, September 1949.

The schools on the accredited list have passed through a regulated procedure. The accrediting process includes personal visits and detailed study for evaluation. The schools of the Interim Classification have been screened for broad and basic principles, philosophy, and performance. Both lists are necessary. Each has its particular use today.

Knowledge about available resources in nursing education is basic for local, state, regional, and national planning for improving nursing education and service. Since the Interim Classification may arouse schools to take action leading to desirable improvement it is of direct significance and importance to public health nursing. Specifically, schools will be stimulated to evaluate themselves and to make efforts to raise their programs to meet the criteria established for accreditation and subsequently to seek accreditation from NNAS.

Both these published lists will aid public

health nursing agencies in establishing priorities for selecting schools for field experience. If young women receive an improved basic nursing education public health nursing will be the gainer in the quality of its recruits for service and for education.

The Interim Classification is another indication to the public and to other professional groups that nursing is making a serious effort to raise its standards. Undertaking the survey demonstrated that nursing accepted realistically Esther Lucile Brown's report, *Nursing For the Future*. The list should go far in clearing up confusion in the minds of parents and young people about choosing a good school of nursing. It will stimulate vocational counselors in high schools and colleges to give more satisfactory guidance concerning nursing.

The Interim Classification at this time is undoubtedly but one link in a chain that will result in vital changes in nursing education and nursing services. The publication is a noteworthy step in nursing history.

UNITED NATIONS DAY–OCTOBER 24

THIS MONTH the birthday of the United Nations will be celebrated. Just four years ago, member nations had deposited the required ratifications of the Charter. The United Nations became an actuality and the Charter became world law.

Because the United Nations is a vehicle for the peoples and governments of the world, it can only progress to the extent that the opinions, support, and courage of citizens everywhere make its progress possible. United Nations Day, October 24, affords Americans an opportunity to consider the purpose and work of the United Nations and its efforts to promote world peace.

Trygve Lie, Secretary General of the United Nations, in a recent report on progress of the United Nations, declared, "To prevent a new world war from breaking out is the main reason for existence of the United Nations."

President Truman issued a proclamation urging the people of the United States to "observe October 24, 1949, as United Nations Day with ceremonies designed to affirm our faith in the objectives of the United Nations, our appreciation of its accomplishments, and our resolve to give active support to its principles."

Public health nurses like other nurses have long been aware of the importance of mutual understanding between the peoples and professions of all the nations. Through participation and sometimes membership over the years in such organizations as the League of Red Cross Societies, the International Council of Nurses, and the League of Nations; through service in the Armed Forces and American Military Government during the war and afterwards, and since 1945, in the specialized agencies of the United Nations itself—United Nations Relief and Rehabilitation Organization, International Emergency Children's Fund, World Health Organization, Food and Agriculture Organization—nurses have come ever closer to the realization of the responsibility of the individual—particularly the professional individual—for the peace of the world. In the words of Pearl Parvin, in the August magazine:

"Much of the work toward international understanding will be accomplished, not on the exalted level of ideas and theories but rather on the functional level where workers capitalize on their common professional interest and work together with a large measure of mutual respect and understanding."

PUBLIC HEALTH NURSING AND MENTAL HYGIENE

Report to the Committee on Mental Hygiene of the National Organization for Public Health Nursing on a project for the promotion of advanced programs of study in mental hygiene

SYBIL H. PEASE, Director of Project

THIS PROJECT[1] was carried out by the National Organization for Public Health Nursing under the guidance of the Mental Hygiene Committee, a subcommittee of the Education Committee. The long range objective was to increase the supply of mental hygiene consultant service available to public health nursing agencies. The project was made possible by a grant to the Minnesota Department of Health, Division of Child Hygiene, from the Children's Bureau, Federal Security Agency, from funds available to the states for maternal and child health. Work was begun in October 1946, and ended April 8, 1948.

Several factors operated to make the project timely and essential.

In 1945 a committee representing the National Committee for Mental Hygiene and five other national organizations in related fields including the NOPHN prepared a statement of the mental health needs of children. Physicians, nurses, social workers, teachers, and others were invited to examine it with a view to defining the contributions of their respective professions. They were asked "to indicate the share in the division of labor that they can take—and to translate it into a program of action."

The NOPHN believed that public health nursing functions in this field needed restatement and that programs for mental hygiene preparation thoughtfully conceived and carefully organized should eventually result in nurses trained more specifically to carry out the functions.

There was a likelihood that many of the nurse veterans who had shared in the psychiatric care of military patients might wish to continue in that field, in hospitals and out of them, in community efforts to prevent mental disorder and promote mental health. It was expected that many of these nurses would seek further preparation.

[1] *Members of the Committee on Mental Hygiene are: Milenka Herc, Michigan, Chairman; Ruth Gilbert, New York; Lucile Petry and Pearl R. Shalit, Public Health Service; Ruth G. Taylor, Children's Bureau; Lillian Salsman, New York; George M. Stevenson, M.D., New York; Margaret S. Taylor, Minnesota; Ruth Hubbard, Anna Fillmore, Olwen Davies, and Katharine Faville, ex officio; and Sybil Pease, Secretary.*

BACKGROUND

Public health nursing agencies were among the first in the community to include consideration of mental hygiene in staff education programs. This extended community facilities for the greater understanding of mental hygiene.

Since 1924, an in-service program of mental hygiene education has been going forward quietly and persistently in a number of public health nursing agencies. By 1932 there were some 20 consultants in as many agencies. This number fluctuated downward in the middle thirties, but rose again to 20 in 1939. The latest figures available indicate that in April 1948 there were 32 persons employed by official and nonofficial public health nursing agencies, who were designated as mental hygiene consultants.

In 1928 the American Association of Psychiatric Social Workers appointed a Committee on Psychiatric Social Work in Public Health Organizations to study the function and methods of the psychiatric social worker in this setting. In 1930 when the NOPHN had added a psychiatric social worker (who was also a public health nurse) to its staff, the Joint Committee of the AAPSW and the NOPHN was formed, and met at intervals from December 1930 to February 1932.[1]

The Joint Committee adopted a statement, prepared by the Field Studies Committee of NOPHN, of the objectives of mental hygiene in public health nursing. This was published in PUBLIC HEALTH NURSING:[2]

1. To make more productive all of the nurse's contacts with individuals and families through her better understanding of human psychology and teaching methods
2. To increase her awareness of the significance of variations of human behavior so that she may make more intelligent use of mental hygiene resources
3. To equip the nurse to assist in the care of the mentally sick in their own homes

[1] Members were: Elizabeth G. Fox, Ruth Gilbert, Glee Hastings, Grace Marcus, Florence Patterson, Sybil H. Pease, Christine Robb and Katharine Tucker, with Elizabeth Brockett and Mrs. Kathleen Larkin, ex officio, and Lois Meredith, visitor.

[2] Committee on Field Studies of the National Organization for Public Health Nursing. Objectives in Public Health Nursing. PUBLIC HEALTH NURSING, vol. 23, September 1931, p. 441.

In 1936 the January News-Letter of the American Association of Psychiatric Social Workers carried an account of the in-service educational mental hygiene programs in six public health nursing organizations. In 1940 an account of these programs was given in *Psychiatric Social Work*.[3] The objectives of the consultants were summarized as:

1. To help the nurse to do better family health work
2. To develop in the nurse a greater ability to recognize mental maladjustment
3. To distinguish between problems in her province and those needing psychiatric treatment
4. To familiarize the nurse with the work of psychiatric clinics and to aid in better cooperative work between the nurse and the clinic as well as other agencies in the community

It is of interest that the term "consultant" was not used in public health nursing agencies at first, but gradually over the years began to supersede the earlier designation of "supervisor" as a more accurately descriptive term. "Consultant" denoted a worker who did not usually take administrative responsibility as did the generalized supervisor, but one to whom the staff nurse and the generalized supervisor, the administrator, the educational director, and others of the staff could turn for help in acquiring and using the "mental hygiene point of view" in their own daily work.

The training of the consultant was the subject of considerable discussion in the Joint Committee and elsewhere. There was fairly general agreement that she should have the full period of training in a school of social work and field work in a mental hygiene clinic or psychiatric agency. In addition, it was recommended that she have field work in a public health nursing agency with a generalized service, or one in which mental hygiene education was emphasized, so that she would not become too centered on definite maladjustments and intensive individual treatment.

As a result of much discussion the Joint Committee formulated three general recommendations in regard to training:

1. The worker should have completed the full two-year course in psychiatric social work with field

[3] French, Lois M. *Psychiatric Social Work*. Commonwealth Fund, 1940. P. 162.

experience in a mental hygiene or psychiatric clinic and if possible also in a family agency.

2. The worker must be familiar with the public health nursing field and know the purposes and problems of her own particular organization.

3. A position of mental hygiene supervisor in a public health nursing agency is not one that should be taken by the young and inexperienced graduate from a school of social work.

The Joint Committee stated that "mental hygiene work in public health nursing organizations is a task which requires maturity, a broad general experience in dealing with people, a seasoned point of view toward personality problems, and the confidence that comes from success in human relationships."

Another significant decision was recorded by the Joint Committee. It accepted as a principle that mental hygiene represented a body of knowledge and a point of view about human behavior which should permeate all service to individuals and families. It was not to be set up as a special service for maladjusted individuals only.

The consultants used a variety of methods.[4] They progressed from rather formal group conferences with staff and supervisors to informal individual conferences with the staff nurse about families selected by herself or by her supervisor. Two factors played a large part in this development. One was that the individual conference allowed the consultant to take account of the widely differing capacities of the staff for accepting and using mental hygiene. It enabled her to begin at the point of individual nurse capacity and allowed the nurse to move at her own pace.

As indicated previously the consultants felt that it was of great importance that they should have direct and informal access to the supervisory and administrative groups as well as to the staff nurse, in order to instill a mental hygiene point of view throughout the agency.

The second factor was that the individual conference afforded a demonstration of a method of teaching other than the didactic, giving the nurse a pattern to follow in her teaching in the home. It was easier for the nurse to accept and use with confidence an informal approach which took its cues from the mother's current needs and interests when the nurse herself had experienced its efficacy in her own conferences with the consultant.

Some of the concepts which the consultants have used as basic to the objectives they sought are the following:

1. Respect for personality is essential.
2. The inseparable nature of mental and physical health is recognized.
3. The incidence of mental disorder can be lessened.
4. Everyone needs help.
5. Behavior of healthy people is as interesting as that of ill people.
6. Differences in behavior are differences in degree, not differences in kind.

Public health nursing agencies made progress throughout these years in integrating mental hygiene into the total fabric of public health nursing. Although consultants were used sporadically, their contribution has been vital.

THE NEW PROJECT

The mental hygiene project undertaken in 1946 by the National Organization for Public Health Nursing was a direct outgrowth of the experience with mental hygiene programs of public health agencies in the last quarter of a century. As stated earlier, its long range objective was to increase the supply of mental hygiene consultant service available to public health nursing agencies.

Several questions arose. Should personnel for this service be sought from among psychiatric social workers? Had the time come when it was feasible to seek mental hygiene consultant personnel from the supervisory group of public health nurses? If so, what additional training would be needed and where should it be secured? What is the present goal of the consultant in working with the public health nurse in the field of mental hygiene? Should the goal be modified in any way?

The NOPHN Mental Hygiene Committee studied these questions and agreed that carefully selected, well prepared public health nursing supervisors without training as social workers but with advanced study in mental hygiene could function as consultants in this area. It was also decided that mental hygiene preparation should not be entirely divorced from some of the content of one of the follow-

[4] French. Op. cit.

ing: psychiatry, clinical psychology, or psychiatric social work. The long and harmonious association with psychiatric social workers as consultants made a combination with psychiatric social work the amalgam of choice. This combination was preferred especially if it was possible to plan for field work in child guidance clinics in which there would be contact also with psychiatrists and psychologists. It was further recognized that public health nursing agencies with mental hygiene consultants had probably incorporated more of the purely preventive point of view in regard to the physical and mental welfare of the infant and preschool child than had any other group and that it might prove possible to find additional field work facilities in such agencies.

It was the consensus that the objectives accepted by the Joint Committee in 1931 were broadly enough stated to serve as goals at present. It was realized, however, that a restatement of goals might be needed if and when federal funds made possible on a nationwide scale a public health approach to the prevention of mental disorder. Such an epidemiological approach[5] might be expected to bring changes in the administrative and functional aspects of public health nursing, cutting across all categories as it would and further clarifying the responsibility in this field which is definitely a part of public health nursing.

The immediate objective for the project was the promotion of advanced programs in one or more universities to prepare public health nursing consultants in mental hygiene. Universities eligible to participate were those in which there were both an approved program in public health nursing and an approved school of social work.

The Mental Hygiene Committee felt that it was necessary to face and follow through all the traditional aspects of the mental hygiene training process. The problems involved seemed fundamentally the same, whether the training was for social work, teaching, the ministry, medicine, or public health nursing. But they thought that after a time the responsibility for the educational job should be taken over by each profession for itself, first by giving special training to selected personnel from its own ranks and then by incorporating special training in each basic educational program. It can probably be said that until this happens, a profession does not wholly accept for its own use this knowledge nor the self-management which is inevitably associated with its responsible use. The material is held at arms length, as something to be used on special occasions or only under careful supervision—not as a vital, essential part of the professional job.

Another question was raised by some members of the committee. They felt that public health nurses could receive their preparation in mental hygiene by enrolling in existing university programs in advanced psychiatric nursing. They felt that these advanced programs included preventive as well as treatment aspects of mental disorder. They believed the contributions of psychiatry, psychology, and psychiatric social work, and the working out of team relationships with them, could be accepted more quickly if the boundaries between them were clearly marked and the training process carried out as nearly as possible within the area labelled psychiatric nursing.

This point of view deserved and was given long consideration. A majority of the Committee felt, however, that while this plan had much to recommend it, the fact was that public health nursing, with its community base and almost complete separation from psychiatric nursing in the past, was really following the logical line of development by seeking "cross-discipline" training. Such training would emphasize the *likenesses* in the basic knowledge and attitudes needed by all those working in the field of mental health rather than the differences in the various disciplines involved. They believed, however, that psychiatric social work had developed a type of supervision which enabled a student to make progress toward better understanding and use of herself than was likely to be achieved by any other method at present. They thought it quite possible that the sug-

[5] Felix, Robert H. Relation of the national mental health act to state health authorities. *Public Health Reports*, v. 62, January 10, 1947, p. 47.

gested plan of training for mental hygiene consultants in public health nursing might be a temporary one; and that there should be as much cooperative planning of a "common core" of instruction as possible between the advanced psychiatric nursing program and the mental hygiene consultant program so that eventually there might be an amalgamation which would preserve the best features of both.

In all their planning, the committee recognized the unfortunate fact that it would be difficult to find enough child guidance clinics and casework agencies for field work since these facilities could scarcely meet the demands made upon them for the training of social workers.

A statement of the functions and background of the consultant and of the general plan for her training—both tentative—was drawn up and accepted by the Committee. The following statement of the function of the public health nurse in mental hygiene was set down by the director of the project in order to clarify the relationship of the public health nurse to other groups as she carries out her own function:

> . . . to use her contact with the whole family unit so skillfully and sensitively that she will be able to appraise the degree of mental as well as physical health of each member of the family through observation and understanding of the interpersonal relationships in the family and the reports given her as to relationships outside the family. Having gradually sensed the emotional temperature of the group and the individuals comprising it, she decides whether medical-nursing resources are adequate for its needs or whether it is likely that some other agency would be more appropriate.
>
> She tries to be as precise in her use of social resources, herself included, as would the physician in his use of the pharmacopeia. She herself is already in the picture—has already become a factor in the situation. If she can handle it, certainly no one would suggest that she should not do so. . . . If we say that her chief responsibilities in the field of mental health are appraisal and preventive health teaching, which is community-wide, it is obvious that the intensive treatment needed in complicated family situations will be the responsibility of case work or psychiatry or both. The nurse will use her mental hygiene knowledge as expertly as do other professional workers, but it will be used differently because her function is different and the result will be supplementation and not duplication. . . .

Three universities among those eligible—Columbia University, the University of Minnesota, and Pittsburgh University—expressed interest in developing a program. These were visited by the director of the project to give assistance in working out their plans. Catholic University and the University of Washington later indicated interest and it was possible to visit the former. Three others, Wayne University, Western Reserve University, and Vanderbilt University, wished to consider the possibilities for strengthening the mental hygiene offered to basic students and to public health nurses. Wayne and Western Reserve were visited, making a total of six universities to which visits were made during the period of the project.

Approximately four weeks were spent in each university and the plan of work was essentially the same in each place. A member of the faculty or of the community—a public health nurse who was interested in mental hygiene—was appointed by the school of nursing to work with the visitor. Also, in most cases, a local committee was formed which made a schedule of the community agencies and the persons to be approached during the visits.

Throughout the field service, a great deal of interpretation of the role of the public health nurse in the mental hygiene movement was done. Interpretation as to the character of her role in relation to that of the social worker was also essential.

The response by the schools of social work to the suggested plan was that of complete willingness to admit well qualified nurses to selected courses given by the schools, coupled with a statement of the impossibility—as foreseen—of finding places among existing resources for these students to obtain the field work in social agencies which was so essential a part of the plan. It was made clear to the schools and to the social agencies that what was wanted was mental hygiene content to be used by nurses in their own field, and that an abbreviated program of training for psychiatric social work was not contemplated. The schools' help was sought in locating nurses who had previous training in social work and who might be interested in acting as coordinators for the proposed advanced programs.

Gradually, during the winter and spring of 1947, plans for a program for the fall began to take shape in the Division of Nursing Education, Teachers College, Columbia University, at the University of Minnesota School of Public Health, and at the University of Pittsburgh School of Nursing. Applications were made by these universities to the Mental Health Division (now the National Institute of Mental Health), Public Health Service, Federal Security Agency, for grants to aid in setting up these programs and for stipends for prospective students. The Division found it possible to make such grants.

It has been recognized at the outset that the mental hygiene programs of study would not be identical and that it would be necessary for each school to build a curriculum from such courses as were available, making changes and adding additional material as experience showed it to be advisable. In no school was a course in the epidemiology of mental disease available. In only one case had it been possible to find a full-time coordinator for the program. Another program eventually succeeded in getting the services of a part-time coordinator.

The programs were offered in the fall of 1947. A total of 21 students were enrolled—11 at Columbia, 7 at Minnesota, and 3 at Pittsburgh. The directors of the programs were members of the NOPHN Mental Hygiene Committee.

The Committee discussed the programs at length at a meeting held on April 8, 1948, some seven months after the first students had been admitted. All agreed that their flexibility and the differences between them were desirable and that experimentation should continue without attempt at crystallization at present.

Discussion returned several times to certain questions, such as the relationship between psychiatric nursing and mental hygiene nursing, the relationship between the fields of nursing and social work, and the relationship between the established team of psychiatrist, psychologist, and psychiatric social worker and the adjacent groups, such as the psychiatric nurse and the public health nurse.

In addition to the visits made to the universities mentioned, certain other communities where there was promise of unique field work opportunities were visited. In this group were Rochester, Minnesota; Cincinnati, Ohio; Roxbury, Massachusetts; White Plains, New York; Baltimore, Maryland; and Philadelphia, Pennsylvania.

In the summer of 1947 a two-weeks workshop in mental hygiene was given at the University of Minnesota, with the director of the mental hygiene project as leader. It was attended by 21 public health nurses. The students were members of the supervisory, consultant, and administrative groups of their respective communities.

CONCLUSION

A worthwhile beginning has been made in achieving the immediate objectives of the project and the long range goals as well. There are three universities offering advanced programs in mental hygiene for public health nurses and other programs are in the process of being developed. The first graduates of the programs are already active as consultants in both official and voluntary public health nursing services. It is expected that a small but fairly constant number of public health nursing consultants will be prepared to work in this special field.

In the year following this project further study of these programs as a basis for accreditation was carried out through a special grant from the Federal Security Agency Public Health Service in 1948.[6]

The questions raised by the Mental Hygiene Committee in its deliberations during the period of the project need further exploration, but the beginning made in the integration of the mental hygiene concept into the public health nursing program may well be a foundation on which much can and will be built.

---

[6] Report of development of criteria for the evaluation of advanced programs of study in psychiatric nursing and mental hygiene under Public Health Service Grant (extending from February 1, 1948 through June 30, 1949) to the National League of Nursing Education, Mary Schmitt, Director of Project. June 30, 1949. Unpublished manuscript.

DIABETIC PATIENT EDUCATION

MALCOLM J. FORD, M.D.

IN A RECENT article, K. Barbara Dormin, R.N., outlined the work of the Jacksonville, Florida, Diabetes Demonstration, a unit of the Diabetes Branch, Division of Chronic Diseases, Public Health Service, Federal Security Agency.[1] Among the programs discussed was the education of the patient. Considerable interest has been expressed in this phase of the program. In this paper we will outline in more detail the development of the educational activities of the Jacksonville Demonstration with particular emphasis on the role of the public health nurse.

As with most public health programs, the nurse is responsible in large measure for whatever success has been achieved in this project. Smillie in discussing the part of the public health nurse in the development of a public health program says "No individual plays a greater part in the development of the public health program than the nurse. Any health organization that does not incorporate the work of the public health nurse as an integral part of its program is sure to be ineffective. The nurse enters most intimately into the lives of the people, wins their confidence, and interprets the purposes of the health department to everyone in the community. Thus her services are indispensable."[2] Our Unit has been fortunate in having competent, enthusiastic public health nurses both in its immediate organization and in the cooperating agencies whose work has given added proof to Dr. Smillie's statement. To them is due a major part of the credit for the accomplishments.

In no disease or pathological condition is the education of the patient a more important part of the treatment than in diabetes mellitus. Supervision by a physician cannot be dispensed with. On the other hand the patient himself has a definite and major role. The injection of insulin, the following of the diet, the program of exercise, the care of the feet, and the testing of the urine are also indispensable to successful treatment and are basically the responsibility of the patient. The best medical supervision will be of no avail if orders are not intelligently and accurately followed by the patient. This fact is recognized by all diabetes specialists.

But what is the patient's situation in all this? First, he is having an emotional reaction to the diagnosis of an incurable disease. He may have heard or known of diabetics dying in coma, losing limbs, or going blind. He is in a state of mind which makes it hard for him to receive any education. Secondly, in the usual patient, knowledge of such technical instruments as syringes, insulin bottles, food scales, diet tables and diabetic diet lists is negligible. Food values, care of the feet, testing of the urine, symptoms of coma, and technics of insulin injection only add to his confusion.

EVERY PATIENT, as least subconsciously, wants to do his job well. Evidence of this is the response to various education projects. In 1947 a public class for diabetics was

Dr. Ford is a senior surgeon in the Public Health Service, Federal Security Agency, and medical officer in charge of the Diabetes Demonstration Unit in Jacksonville, Florida.

started by the Unit in a local hospital. Jacksonville has a population of approximately 225,000. Only a small amount of publicity was given to the class. The room given by the hospital for the class seats 30 persons comfortably. One hundred and twenty-five diabetics came to class that day, an August afternoon! Projects of a similar nature in other areas have had the same degree of response.[3,4]

The leading diabetes specialists and the clinics treating the largest number of diabetics recognize the need of special instruction for diabetic patients. All the larger diabetes clinics have formal classes for diabetics supplemented by individual instructions. Many diabetes specialists have written special manuals for the diabetic patient. However, this type of education does not reach, in any great amount, the larger number of diabetics who are patients of general practitioners. They need instruction as much as patients attending these large clinics. Dr. Elliott Joslin, one of the greatest of all diabetes specialists, has recognized the place of the official agency in this field. He has stated as follows: "In the future just as education helps in the management of these two groups, the hospital and the ambulatory, education should be made available to the greatest diabetic group of all, namely those whom the family doctor treats. This is the place where the government can step in and make available to the practicing physician opportunities for control of the disease which now are only available to a few physicians on hospital staffs."[5]

Certainly, the structure of the public health profession lends itself to the assuming of such services. A sizable proportion of the profession are nurses, nutritionists, and physicians. One of the basic programs in public health is health education. Public health nurses have for years been teaching expectant mothers, both in ante- and postpartal care and in care of the infant. Their work in other fields such as communicable disease education has contributed much to control. There is no doubt that public health workers can, with special refresher courses, do an excellent job in the teaching of diabetic patients. Where this program is worked out on a sound administrative basis in cooperation with the local medical profession, there should be no criticism on the part of doctors that public health is interfering with the practice of medicine. Actually this type of program does not interfere with the doctor's practice but, as with all good public health programs, assists him in caring for the health of his patients.

The Jacksonville project has been teaching public classes for diabetics for approximately 18 months. During this time 650 diabetics have attended. Several observations have been made during these experiences:

1. Patients begin to lose interest and fail to return after approximately six classes.
2. The maximum time that their interest can be held at each session is approximately 1½ hours.
3. Patients are most deficient in their knowledge of:
   a. The proper care of the feet
   b. The diet and a proper attitude toward it
   c. The action of insulin in the body
   d. The causes of insulin reaction

By considering the items of knowledge that specialists say a diabetic should have in order properly to control his condition, and what patients actually know, the following list of topics has been evolved. The amount of time and emphasis given to each has been changed where results of post-testing the patients indicated this was needed. After each topic appears the teaching aim:

1. Nature of diabetes
   Aim: To develop a wholesome attitude toward diabetes through the understanding of the condition and of its control
2. Insulin and its use
   Aim: To develop an understanding of the nature of diabetes in relation to insulin
3. Nutrition and diabetes
   Aim: To achieve better diabetes control through use of acquired dietary knowledge
4. Insulin reaction and diabetic coma
   Aim: To develop an understanding of the blood sugar in relation to insulin reaction and diabetic coma so that these two complications of diabetes may be prevented

5. Carbohydrate exchanges
   Aim: To use the carbohydrate exchange list* as an aid in meal planning in order to keep the blood sugar at a normal level.
6. Tests in diabetes
   Aim: An understanding of the use of various chemical tests for the detection and control of diabetes
7. Fruits and vegetables
   Aim: To use fruits and vegetables in the diet in the proper amounts
8. Aids in the prevention of complications
   Aim: To develop the understanding that control of the diabetic condition is of first importance in the prevention of complications, accompanied with personal hygiene measures
9. Proteins and fats
   Aim: To use the protein and fat exchange lists as an aid in meal planning in order to keep the diabetic condition in good control
10. Points of special interest in everyday living
    Aim: The development of a sense of responsibility for a healthful daily living, and for the maintenance of a healthy attitude towards the diabetic condition
11. Milk and special menus
    Aim: To use the meal plan and exchange lists as a guide in selecting the food eaten in order to maintain good control of the diabetic condition.

The nurses have insisted that the physician give the first lesson in order to lend prestige to the class and to the teaching of the dietitian and nurse in subsequent classes. This particular topic, however, could be well handled by a nurse if the services of a physician cannot be secured. The remainder of the topics are divided evenly between the nurse and the dietitian-nutritionist assigned to the demonstration Unit.

THE GENERAL principles which have been applied to our teaching are in general applicable to any type of educational endeavor. For purposes of emphasis, however, we should like to list these principles:

1. Use simple, non-technical language.
2. Stimulate discussion and group decision among patients.
3. Develop educational aids stimulating not only the auditory, but the visual, touch, and motion senses.
4. Teach technics by having them actually performed by the patients.
5. Create a wholesome attitude toward the disease through a friendly, optimistic, and somewhat informal atmosphere.

An attempt has been made to glean the field of diabetic literature for existing education helps such as pamphlets, charts, and moving pictures. Several very excellent ones have been found, but in other cases original pieces have been developed. The Unit is in the process of developing an overall teaching manual of a type which has not been found in the previously existing literature. Many manuals for diabetic patients are on the market, but they are of no specific aid to the person undertaking to conduct a class.

In order to fill in the gaps in the knowledge of the diabetic and to sustain his ambition to maintain good control, a monthly news letter has been evolved. This is a one-page letter measuring 8½ x 14 inches. In this the staff has constantly endeavored to use short sentences and simple words, interspersed with pictures and diagrams. The mimeograph machine lends itself successfully to this type of news letter and this reduces the cost. The contents have been along the line of news items concerning new insulins, new syringes, and the like, together with continued advice on proper methods of control of diabetes and maintenance of health in general. Attempts have also been made to reiterate the basic principles brought out in the formal classes. The reasoning back of this news letter is that in order to maintain constant vigilance against a chronic and incurable disease, the patient must have recurring encouragement. It also reaches persons who for one reason or another have not attended our classes. To date we have not analyzed statistically the effect on our program, but judging from the responses of patients and physicians, the news letter is

* The exchange list referred to here and in subsequent topics are those contained in the booklet "Meal Planning" prepared by the U. S. Public Health Service, in cooperation with the American Diabetes Association and the American Dietetic Association.

successful. One patient even advised us that she did not need to come to the class since she received the bulletin and read it each month. This is not the desired effect of the news letter, but it does indicate that it is supplementing our other education programs. Patients are continually advising us by letter and telephone of changes in address in order that they will continue to receive the bulletin. Rather than objecting to this project, the local physicians have praised it highly and many are voluntarily sending us the names of their patients in order to have them placed on the mailing list.

As IN OTHER diseases and conditions, we feel that the nurse's visiting in the home has an important part in the control of diabetes. This avails the patient of individual attention and instruction by the nurse. She can observe the problems of the patient in his own environment and can offer many helpful suggestions on the handling of these problems. Many home situations detrimental to control of diabetes are observed and are corrected through the ingenuity of the public health nurse. Emotional, economic, and familial factors are all of the utmost importance in the control of diabetes and it is through home visiting that the nurse often gains excellent insight into these individual situations.

Universal improvement in the education of the diabetic patient will contribute markedly to the control of chronic disease, the future's greatest public health problem. The public health nurse has an excellent opportunity to assist in obtaining this objective. She will be compensated for her endeavors by the thrill of accomplishment. A patient came to the public class in Jacksonville greatly upset because of a reprimand from her physician for not following her diet and allowing her diabetes to get out of control. The nurse conducting the class found this patient to be improperly measuring her insulin. Improvement of her diabetes followed correction of this error. Following up with a home visit the nurse found the patient using a poor technic of insulin injection. Following institution of proper technic, the diabetes came under excellent control. The physician gave the majority of the credit for this accomplishment to the public health nurse. The patient was no less appreciative. Such an opportunity may present itself to any public health nurse. She should be ready to make the most of it.

REFERENCES

[1] Dormin, K. Barbara. Public health nurse in diabetes control. PUBLIC HEALTH NURSING, Vol. 41, January 1949, p. 9-12.

[2] Smillie, Wilson G. *Public Health Administration in the United States.* New York, Macmillan Company, 1947, p. 228.

[3] Newman, M. E. and Smith, M. R. Teaching diabetic patients in a rural community. *American Journal of Nursing,* Vol. 42, October 1942, p. 1154-1156.

[4] Rosenberger, D. M. School for diabetics. *Hospitals,* Vol. 21, July 1947, p. 45-47.

[5] Joslin, Elliott P. et al. *Treatment of Diabetes Mellitus.* Philadelphia, Lea and Febiger, 1946, p. 19.

LIFE WITH A DIABETIC

SIXTEEN years ago when my mother learned she had diabetes she was stricken, convinced that life was over for her. Sixty-five years of age at the time, she was vigorous and active. Slightly under five feet tall, she weighed nearly one hundred and ninety pounds. The discipline of a chronic illness was a new and difficult thing for her to face. She had always maintained, and honestly believed, that she was a "light eater." The weighed diet prescribed at first was most distasteful but it exploded the myth of her small appetite. My mother likes to eat. She is a good cook and, it was revealed, there had been many small

snacks during the day. At any rate, within a few months after starting the restricted diet her weight was reduced by nearly thirty pounds. I am convinced the discovery of the diabetes added ten years to her life.

Because I am a nurse it was taken for granted by the doctor, the family, friends, my mother, and myself, that I would administer the insulin. I doubt the wisdom of this decision. My mother had always been extremely independent. By keeping her dependent on me for her insulin, we destroyed some of her independence. Being a nurse is not a particular advantage in one's own family. If a bruise occurs after an administration of insulin or if the needle prick hurts more than usual, it is easy to remember that the offender is a daughter to whom one has expressed one's displeasure all one's life when occasion presented. But the insulin was easier to control than the diet. While my mother was still able to do the family marketing, the temptation to buy things not on her diet was great. Doughnuts were purchased for me. I didn't eat them because I don't like them but I never knew them to be thrown out. Suggestions that her diet was not being followed were met with irritable comments on my lack of respect. She disliked being "watched." After a particularly serious infraction of rules, when hospitalization was necessary for blood sugar regulation, I decided to give her the responsibility for testing her urine for sugar. We use the Benedict Solution test and her pride in the management of the simple procedure gave me my first hint that I had made a mistake in not teaching her to give herself insulin. The dietary indiscretions did not stop entirely—I doubt that they do after sixty-five—but I noticed that when a slight trace of sugar was shown in the test, certain suspect foods disappeared from my menus. Once when her weight threatened to become excessive I brought home a small but authoritative pamphlet on diabetes. I left it lying about entirely without comment. The next day at breakfast she made casual reference to facts she had read. When I left for work, the booklet was at her favorite window, her glasses on top of it. That evening she asked to be weighed.

At eighty-one my mother is still active about the house. She has never been entirely reconciled to her diabetes but it has certainly not handicapped her greatly. With her failing eyesight I have taken over the care of her feet. This would have been necessary if she had not had diabetes. I have learned a number of things:

Even the older patient should be allowed to manage her own diabetes.

When a patient is dependent on a member of her family to give her insulin, the activities of both parties are limited.

Where guidance is necessary it should be as objective as possible. An authentic piece of literature on diabetes or an occasional lecture on the subject by an authority add strength to the teaching of the family.

A patient who is a diabetic must make up his or her mind to give up elaborate foods. This does not mean that the diet must be monotonous. Fresh and water-packed fruits are available the year around, and with the use of a bit of imagination menus can be very attractive. The plain gelatines lend themselves well to desserts and salads. Fruit combinations of the 10 percent fruits with a small amount of fruits of higher carbohydrate content for flavor and variety can be used for the entire family. The vegetables and meats allowed, prepared in simple ways in a casserole, are welcomed as a change. On high days and holidays we have found that a small wedge of plain angel food cake or a small amount of vanilla ice cream does much for the morale and little damage to the blood sugar. With little modification, the family can eat the diabetic diet to their benefit. It is balanced, adequate and simple—and it is not conducive to overweight.

Diabetes can be an interesting experience in living. Its control is a discipline but it is rewarding in added years of activity even for those past middle age.

ANONYMOUS

THE 1949 CENSUS OF PUBLIC HEALTH NURSES

ANNA HEISLER, R.N.

THE YEAR 1949 can boast of the largest number of nurses employed for public health work in the history of public health nursing in the United States.

The 23,373 total for this year exceeds by 768 the previous high record attained in 1948. In most of the groupings considered separately (Table 1), the 1949 figure is the highest ever attained.

Copies of the tabulations of the 1949 data relating to number and qualifications of nurses employed for public health work in the United States are available from the Washington office of the Public Health Service and the regional offices of the Federal Security Agency. The tables are derived from reports prepared by the state directors of public health nursing for their respective states.

NUMBER OF NURSES IN VARIOUS CATEGORIES

The number of nurses employed by rural official public health agencies increased pretty consistently from 1937 to 1943, rising from 3121 to 5127. It has taken 6 years for these rural agencies to recover from the impact of the war and build up their nursing personnel beyond the 5000 mark. The 1949 total, including all categories of rural nurses, is the highest ever recorded. The increase, however, was not distributed uniformly throughout the states. Fifteen states and Alaska showed the highest numbers of nurses ever employed by rural official agencies; 9 states, Hawaii, and the Virgin Islands about the same numbers over a period of years; 27 states reported fewer rural nurses in 1949 than in early years.

In 1937 urban official public health agencies reported a total of 4451 nurses. From 1938 through 1947 the number ranged from approximately 5200 to 5900. In the last two years the number has passed 6000.

The total number of nurses employed by boards of education recorded in 1937 was 3477. From 1938 through 1946 the number see-sawed back and forth across the 4000 mark; since 1946 there has been a steady increase to the 1949 high of 5168. The number of rural school nurses has risen gradually since 1944. The gain of 259 rural school nurses over the 1948 figure more than compensated for the loss of 110 urban school nurses, and resulted in a net gain of 149 school nurses. The 35 percent reduction of school nurses in New Jersey results from the change of status of certain nurses employed by boards of education, from public health nurse to health educator.

From 1937 through 1942 local non-official public health agencies reported annually almost 6000 nurses in their employment. Since 1943 the number has been approximately 5000.

INCREASE IN TOTAL NURSES EMPLOYED

From 1941 to 1946 the total number of nurses employed in public health work hovered around 20,000. Beginning in 1947, a gain of approximately 1000 nurses each year has been made.

Senior Nurse Officer (R) Anna Heisler is assistant chief, Division of Public Health Nursing, Public Health Service, Federal Security Agency, Washington, D. C.

TABLE 1. TOTAL NUMBER OF NURSES EMPLOYED FOR PUBLIC HEALTH WORK[1] IN THE UNITED STATES, IN THE TERRITORIES OF HAWAII AND ALASKA, AND IN PUERTO RICO AND THE VIRGIN ISLANDS ON JANUARY FIRST OF THE YEARS 1945, 1946, 1947, 1948, 1949.

	1945	1946	1947	1948	1949
Grand total[1]	20,818	20,672	21,499	22,605	23,373
State agencies	869	946	993	1,003	1,031
Local official agencies					
Rural	4,938	4,665	4,590	4,863	5,406
Urban	5,700	5,805	5,928	6,308	6,498
Local boards of education	4,321	4,276	4,637	5,019	5,168
Local nonofficial agencies	4,742	4,655	5,023	5,057	4,898
Schools of nursing	[2]	84	102	133	130
National agencies[3] and universities[4]	248	241	226	222	242
Number of counties having no nurses engaged in full-time public health work in rural areas	909	1,133	1,087	1,050	936
Number of incorporated cities and towns (population 10,000 or more) having no nurses engaged in full-time public health work	9	23	18	23	17

[1] Exclusive of industrial nurses.
[2] Data not available for 1945.
[3] A considerable number of nurses employed by the American Red Cross are engaged in activities that are not strictly public health nursing.
[4] Universities offering programs of study in public health nursing approved by the National Organization for Public Health Nursing.

The number of staff nurses remained in the 18,000's from 1941 through 1947. In 1948 there was a gain of almost 1000 over the 1947 total; and 1949 saw a gain of 660 over the 1948 figure.

This increase of 660 in number of staff nurses, over the 1948 total, is distributed over 42 states. In 13 states and territories the percentage of gain from 1948 to 1949 exceeded 10 percent. In 38 of the states a steady increase in staff nurses is noted since 1946.

The number of supervisors has steadily increased since 1943 from a total of 1951 to 2525 in 1949.

POPULATION RATIO

The increase in number of nurses engaged in public health work has more than kept pace with the increase in population, as shown by the average population per staff nurse, 7143 in 1949, as compared with 7211 per staff nurse in 1948. All states except three (Hawaii, Maryland, and Mississippi) have shown an increase in population; and all except 9 have had an increase in number of staff nurses. In 41 states the increase in staff nurses has been sufficient to lighten the average population load per nurse. In Hawaii, because of a large drop in population, the number of persons per staff nurse has markedly decreased, in spite of a slight decrease in number of nurses. In 3 states the average population per nurse has remained stationary. Nine states show an increase in the staff nurse's load over 1948. In 6 of these 9, the state reports a decrease in total number of staff nurses.

It is interesting to note that for the three years 1946, 1947, and 1948 twenty-one states had an average ratio of 1 staff nurse to 10,000 or more persons; in the next group 21 states had a ratio of 1 staff nurse to an average of 6000 to 9000; and 11 states had a ratio of 1 staff nurse to 5000 or fewer persons. It is interesting also that the various states adhered, almost without exception, during those 3 years, to their respective groupings. In 1949, for the first time, Wyoming moved out of the 1 to 10,000 ratio; and 4 new states moved into the 1 to 5000 class, District of Columbia, Maryland, New Mexico, and Pennsylvania. Twenty-two states show a consistent lessening of the average population per staff nurse for the last four years; 13 others show a decrease in 1949 only over the last two years.

In this connection, however, it will be remembered that public health authorities

TABLE 2. PERCENTAGE OF NURSES WHO HAD COMPLETED A YEAR OF ACADEMIC PREPARATION IN PUBLIC HEALTH NURSING AND PERCENTAGE WHO HELD COLLEGE DEGREES.

Type of agency	Public health nursing study			College Degree		
	1940	1944	1949	1940	1944	1949
Supervising Nurses						
All agencies	57.4	69.6	76.3	28.8	39.9	51.7
State	66.2	84.5	85.0	30.0	46.6	63.3
Rural, official	68.8	80.4	85.2	39.0	48.1	59.7
Urban, official	41.3	58.7	69.4	17.8	28.9	42.3
Bd. of education	39.7	38.3	46.8	22.2	25.9	30.9
Nonofficial	58.8	67.7	74.8	31.5	42.2	49.2
Staff Nurses						
All agencies	19.3	24.6	27.4	7.4	10.0	14.0
State	15.0	29.3	24.5	6.1	8.7	11.0
Rural, official	27.5	34.4	36.0	9.3	12.5	15.4
Urban, official	12.1	19.6	24.0	2.8	6.0	12.1
Bd. of education	19.1	22.1	27.1	8.9	12.1	15.8
Nonofficial	17.6	21.2	22.7	9.3	10.7	13.1

recommend the employment of nurses in ratio 1 to 5000 population for all public health nursing service exclusive of bedside care of the sick, and 1 to 2000 population when bedside care is included.

PREPARATION IN PUBLIC HEALTH NURSING

The percentage of nurses who have completed at least one academic year of public health nursing study at a university offering an approved program has gradually but steadily improved since 1946. Of the 22,820 nurses reporting educational qualifications in 1949, it is found that 32.8 percent had completed a year of academic preparation in public health nursing. In 23 of the states and territories, the percentage of nurses thus qualified exceeds the general average, and ranges upward from 36.8 percent to 86.2 percent. Fourteen states have reached their all-time high in 1949. Many of the states, particularly those that started with low percentages of qualified personnel, are showing notable progress.

In some states the percentage of nurses who have attained the year of public health preparation has doubled in the 10 years during which annual reports have been available. The percentages presented in Table 2 indicate clearly the upward trend in educational attainments of both supervisory and staff nurses in virtually every type of public health agency. State health departments alone showed a drop in 1949 in the percent of staff nurses with a year of academic preparation in public health nursing.

SPECIAL CONSULTANTS

A review of the data on special consultants for 1948 and 1949 shows a slight increase in total number of consultants, an increase in number employed by local agencies, an increase in the number who hold college degrees, and also an increase in the number who have completed at least a year of public health nursing study in a university offering an approved program of public health nursing. The percentage, as well as the number, of consultants with college degrees and the percentage who have completed a year of college preparation in public health nursing has also risen.

PUBLIC HEALTH NURSES IN A VA CLINIC

MYRTLE HORNBUCKLE MILLER, R.N.

PUBLIC health nurses working in the outpatient clinics of the Veterans Administration regional offices since 1948 are expected to emphasize health education and to assist in bringing community health services to the veteran. These services were inaugurated when Dr. Paul B. Magnuson, chief medical director of the Veterans Administration, authorized employment of public health nurses.

Let us suppose you are interested in visiting one of these outpatient clinics. The picture of one regional office clinic may differ from that of the next. You have chosen to visit the clinic in San Francisco, situated in the heart of the downtown district. From the windows you can see a wide expanse of the Golden Gate and the blue Pacific with its network of gleaming bridges connecting the Bay Cities area with San Francisco. You think at once of the many veterans who will come here for guidance and medical care.

Many services are provided in the regional office medical division. Veterans come for examination for pensions, for treatment, and to determine eligibility for domicillary care and for hospitalization. Physicians in general medicine and specialists are in attendance, and plans are under way for the expansion of facilities so that extensive diagnostic treatment and minor surgery may be carried out.

Mrs. Miller is chief nurse, V.A. Regional Office in San Francisco. *Her article is published with permission of the chief medical director, Department of Medicine and Surgery, Veterans Administration, who assumes no responsibility for the opinions expressed or the conclusions drawn by the author.*

The medical division provides the following services: neuropsychiatric; ear, eye, nose, and throat; medical rehabilitation; prosthetic; plastic eye; social service; pharmacy; clinical laboratory, and many others.

Each patient is interviewed by a nurse before he sees the doctor. The initial interview naturally is of special importance in establishing rapport and also in determining the attitude of the patient about accepting treatment and instruction. On return visits the patient is encouraged to discuss new developments in his condition or ask questions about his family health problems. The public health nurse with experience in family situations, in industry, with skill in health teaching and interviewing, and with knowledge of community resources will find this background valuable in interviewing.

Direct nursing care to the patient and assistance to the physician are the primary functions of the public health nurse in the Veterans Administration clinic; health education is an integral part of these functions. The nurse writes notes for the doctor to have when he sees the patient. These include notations of temperature, pulse, and respiration, and of blood pressure, and brief comments about the patient's history and symptoms. Many duties which are mechanical in nature are delegated to trained nursing assistants. This allows more time to develop the public health nurses as leaders and teachers.

Those patients who would benefit from home nursing visits are referred to the local community public health nursing organization. Notations concerning the patient's clinic visit are sent to either the health de-

partment or to the visiting nurse association whose nurse visits in the veteran's home.

HEALTH EDUCATION is an essential part of the clinic nurse's service. Therefore she is alert to opportunities for instruction not only in the specific area of the immediate needs of the patient but also in matters concerning accident prevention, control of communicable disease, the value of good nutrition, and other important aspects of good health. The nurse watches for evidences of family maladjustment. She refers the veteran to social service or to the mental hygiene clinic for service-connected disabilities. In all of her interviews she uses educational pamphlets and posters from city and state health departments and from a variety of other sources, such as the dairy council and the dental association.

The nurse in the veterans outpatient clinic has an unusual opportunity to provide health education for men who are fathers of families. Fathers are not often home when the public health nurse visits and therefore do not have direct instruction in health matters. We experience a real thrill in the San Francisco office when proud fathers carry away first-hand information on keeping their families well. There is a feeling of teamwork inherent in the situation. We know the public health nurse in the field has probably discussed the same health information with the mother. Now father and mother share equally in family health planning.

In our San Francisco office the veteran in the waiting room is invited by the nurse or volunteer worker into a movie projection room. Here volunteers run off films supplied free of charge as a community service by the California State Department of Health, the United States Department of Agriculture, the United States Department of Forestry, the University of California, and by other agencies. We are also fortunate in having some sport films available. Thus we make a sandwich of films on soil conservation, forestry, fire control, control of tuberculosis, venereal diseases—and the football game. The time used in waiting to be called by the physician is spent profitably by the veterans from rural and urban areas of California. When they complete their visits there exists a better understanding of the health and conservation services available within their own district.

In the tuberculosis clinic, as in the other services, the patient is first interviewed by the public health nurse. Many patients with tuberculosis must wait for admission to a hospital, and it is here that the nurse can start instruction about the home care of tuberculosis. She has a part in helping the patient reach a desirable mental attitude towards his disease. She tries to get the patient to accept his role as a teacher and leader in the prevention of tuberculosis, and also to accept his responsibility for his own recovery. He is helped to feel that he is a part of the team, a team made up of physicians, nurses, family, social workers, and patient. If the patient must remain at home while he awaits hospital admittance the nurse in the clinic demonstrates certain precautionary measures to help him understand ways of protecting his family. He is referred to the local community public health nursing organization, and frequently members of his family are advised to take the Red Cross home nursing classes so that they will become more adept and understanding in their care of the patient.

Of course, the amount of instruction given the patient at any one time varies with his condition and needs and his ability to accept the situation. Usually he is given some preliminary information about nutrition, and about community resources available for his care during his acute illness and convalescence. A variety of pamphlets is used to reinforce the information given him, and also to provide material which he may take to his family.

When the tuberculous veteran leaves the nursing conference he has a feeling of sharing in his own treatment and recovery. We try to avoid demands and hope our suggestions will stimulate his thoughts toward a positive approach to his recovery. He is reminded that his community has agencies which are interested in him and that their services are available for the solution of problems that may arise. He is aware of the allied efforts of the Veterans Administration and the community organizations for his recovery. The

knowledge that their combined teamwork will be directed toward the interest of this veteran as an individual is a reassuring factor in his new plan for health.

If the instruction given in the clinic is put into practice the nurse in the home can proceed to build her teaching on what the patient and family have already learned and are applying. In instances where the clinic teaching has not been accepted or absorbed the public health nurse in the home must review and repeat basic information.

IN ANY HEALTH SERVICE there is need for working closely with other official and nonofficial health and welfare agencies. To clear some of the points which caused confusion, an orientation period for community agencies was arranged at the San Francisco regional office clinic through the Committee on Veterans Administration Voluntary Service. The chief medical officer described the services at the clinic and visitors were taken on a tour through the building. This proved to be most satisfying for all concerned.

Through the Veterans Administration Voluntary Service discussions were held with various agencies to determine what voluntary services they could provide for the clinic. The volunteers not only contributed their service but also interpreted the VA program to the community. In the outpatient clinic we have been most fortunate as our volunteers include Red Cross nurse's aides and volunteer registered nurses with public health nursing preparation. The volunteer public health nurses work in the nurses' conference rooms and the emergency rooms. The nurse's aides work in the doctor's offices and in the dressing rooms. The Red Cross staff aides help the veterans at the information desk and in filling out necessary papers. A spirit of fellowship permeates the teamwork of the volunteer workers and the VA staff members. They enjoy the daily experience of serving and learning together. There is frequent contact between the nursing staffs of the Veterans Administration, the California Health Department, and the San Francisco Department of Health. Interest, guidance, and audio-visual material have been given freely to the VA clinic by the state and city divisions of health education. We not only teach the patient to use his community resources but also we use the excellent services provided by all the agencies situated in the San Francisco area.

The community nursing program for the VA was planned by Dorothy Wheeler, the director of the Nursing Service, and Ruth Addams, the deputy director, who has had extensive experience as a public health nurse. One of the duties of public health nurses in the regional office clinics is to assist in the coordination of the Home Town Medical Care Plan and the extension of nursing care through the already existing community nursing agencies. The National Organization for Public Health Nursing has given counsel in developing this program. A pilot study of the VA community nursing program is now under way in the New England area, and nurses look forward to hearing about this when a report is available.

A DYNAMIC SCHOOL HEALTH PROGRAM

CATHARINA HUNTSMAN, R.N.

COOPERATION and flexibility are the keynotes of a successfully active school health service. Here are some examples of ways in which it is done in Bronxville School

Much of the most important work of the school health service is accomplished in cooperation with the classroom teacher. Take, for example, the shy new kindergartner. Frequently, the only experience a 5-year-old has had with a medical office is associated with discomfort and fears—injections, illness or accidents. The kindergartner may need help in learning that the school health office is a friendly place. Early in the fall, the school-nurse-teacher takes time out of her busy schedule for short visits to these beginners in their own classrooms. Some of them she may meet as brothers or sisters of older school children whom she knows, some of them may be working on projects or games in which she can share an interest and to all of them she can give the feeling that they are real persons who belong to the school and are a part of its work. At this first visit, she usually invites them to return her call some day when she will show them her room. On the day the group visits the office, the nurse chats with them, shows them all around; she may even weigh some of them. For individual children who need special help in overcoming their fears of a medical office, the teacher may organize a "messenger service" whereby notes from the teacher to the nurse are carried by a team of two or three children, one of whom may be the apprehensive child. It is not long before every kindergarten child looks upon the nurse as his special friend. When, late in the fall, the time for routine hearing tests, vision tests and physical examinations comes around, the 5-year-old tackles them happily as being interesting new games and experiences.

Another illustration of the value of cooperation with the classroom teacher comes from a slightly older group. The telephone rang one noon hour. It was a sixth grade teacher in whose social studies class that morning the children had been talking about our community. A question had been asked by one of the boys which led to the discussion of community health protection. The teacher felt that the children's experiences would be enriched if they could talk with the nurse-teacher about the more technical aspects of the public health activities in their community. The next day the nurse spent almost an hour in their room, and when she left, she asked the children if they were interested in investigating for themselves some of the places and facilities about which she had told them. The teacher and the nurse then developed a plan by which groups from the class might visit the Village Hall to learn about sewage and garbage disposal, the public health nursing center to learn about clinics, and the local hospital to find out about the laboratories and the care of patients who were not able to pay

Miss Huntsman is on the staff of the Bronxville Public School, Bronxville, New York.

private physicians. Reports written by the children after these visits showed how worth while this cooperative venture had been.

Occasionally a teacher needs help in handling a difficult child. Very often the problem is such that an easy solution cannot be reached without the cooperative help of many people. Our school has a plan which frequently offers such help. A conference is arranged where the members of the staff most interested in the particular child meet to discuss his problem. The group includes not only his present teachers, but those who know him from other years, and the special teachers, such as, art, music, physical education, science. The administrator and the personnel from the health and guidance departments also participate. Let us outline such a meeting as it convened one noon hour in the health office over an informal sandwich lunch.

Johnnie Smith was the lad who needed help and his present teacher presented the story. He was a 9-year-old third grader who assumed a superior attitude in his associations with his classmates. He had few friends and was seldom included in the plans of the group. Over against this poor social adjustment, was the high scholastic record Johnny showed—two years ahead of his class in reading and an almost adult knowledge in science.

His former teacher added the observation that he had never been particularly popular with his classmates but that when he first came to this school two years before, the children had been more tolerant and had obviously admired his scholastic abilities. His science teacher added that his father was a scientist and had given him many opportunities at home to experiment. Both of his parents encouraged his scientific interests through books, museum trips, and family conversations. The art and music teachers agreed with the picture. The psychometric tester reported that his I.Q. was 148. No Rorschach had been done.

The physical education teacher remarked that Johnnie was clumsy, with poor muscular coordination and very few physical skills. He was rarely chosen by his classmates to be on teams, was bossy and full of alibis to excuse his poor sportsmanship.

The school physician added that a recent health examination had not revealed any abnormal physical findings. However, during the parent conference at the time of Johnnie's physical examination, the mother had given the history that when he was about five years old, he had had a series of childhood diseases within a short period, culminating in an undiagnosed illness with a temporary heart murmur. It had been necessary to curtail Johnnie's activities for several months at that time, and Mrs. Smith had devoted herself to amusing him, planning for him, and being with him. It seemed probable that the over-anxious mother had welcomed her son's dependence on her and had been slow to give him needed independence.

The school physician talked with Johnnie's private pediatrician on the telephone. He reported that there was no reason why the boy could not participate in all school activities.

That was the story that was obtained in a half hour staff conference. This was followed by a discussion as to a possible treatment. The following plan was worked out: Since Johnnie could well afford to miss his reading periods and needed the experience of physical satisfactions, the physical education teacher invited him to help her with her first grade class which she said was very large for her to handle alone. Johnnie had to run, skip, jump, throw balls with the younger group and frequently found that the little one could excel him. He was seen practicing some of the skills and also was using his leadership abilities in a constructive but supervised way. Within a comparatively short time, he was participating in his own third grade group and even being chosen on teams. He no longer had to get his satisfaction by bragging, showing off and being smarty.

These informal luncheon conferences have proved so helpful and rewarding that the classroom teachers constantly ask for the opportunity to present a problem to the group. The nurse-teacher acts as the official coordinator who calls the meetings and notifies the selected staff members who are most concerned.

In addition to these meetings of larger groups, there are weekly scheduled conferences between the health department and the guidance staff where there is an opportunity for an easy exchange of information and suggestions for meeting some of the lesser problems of the children.

As ALL NURSES working in schools know, a great deal of information is collected in the health office. It is useless unless it is made available to those most closely concerned with the welfare of the child. Over a period of time, these bits of information often dovetail into a pretty valuable picture. For example, it is possible to discuss more intelligently the poor mental health of a child with his bewildered parents when our records show too large a number of half-day absences linked with a minimum of adverse findings at physical examinations.

The local physicians also find our records useful. Last spring a school child sustained a deep laceration and the doctor who was called in the emergency wished to administer tetanus. The patient was new to the doctor and the child's condition made it inadvisable

to give tetanus anti-serum. The school was called to learn whether tetanus toxoid immunization had previously been given.

It is the classroom teachers who derive the most help from our records. The health office personnel have taken the responsibility for initiating a system whereby the teachers are informed routinely about the physical health of the pupils in their class. For example, after a rather thorough physical screening of all the school children within the first weeks of the fall term, a schedule is made for a half hour conference between the school physician and each teacher. We feel that this method of exchange of observations and data is better than written referrals, as there is more opportunity to discuss the emotional, social, psychological, and physical health of each pupil. Of course, all through the year, notification of pertinent findings requiring immediate consideration—change of seating, program, et cetera—is made by the doctor or nurse to the teachers. Those findings that do not need immediate attention are reported in writing as soon as convenient. Toward the close of the term, when teachers are writing an annual summary of the school year for each child, the health office sends each teacher an outline report of the pupils in her class. These charts contain exact reasons for any abnormal number of absences and an estimate of all observations, contacts and physical examinations that have been made.

Another member of the staff who makes use of materials in the health office is the director of vocations and graduate study. Each year before she begins her work with the pupils of the upper school, she requests a brief recapitulation of the entire school life of each child, including outstanding data from our accumulated health and attendance records.

While, in general, most of the cooperative program of the school health department deals pretty directly with the child, there is one particular activity that affects the pupil less directly. At least twice a year, the nurse and physician make a complete inspection of the school buildings. Written reports are made to the business office and the administrator. Copies are kept in the health office. It was obvious, some years ago, that the lighting of some of the classrooms was inadequate and outdated. Light-meter readings that were below the advisable minimum were reported to the business manager in the routine way, but no action was taken. Other matters crowded the lighting problem off the school budget. At a meeting of the health committee of the PTA, when it was asked if any special need had arisen, the subject of lighting was discussed. One of the active members of this committee, Mrs. Jones, was the wife of a board of education member. As an executive of an engineering company, Mr. Jones consulted a lighting specialist, who verified the findings. The Board of Education then voted the funds to equip the poorest room with fluorescent lights and scientifically painted walls. The following spring when the board was considering summer work on the building, funds were made available to equip two other rooms. The health department building inspection reports were consulted to determine which rooms should be given precedence. Each year thereafter the lighting of a few rooms has been improved until now all are within normal range. Now that the members of the PTA health committee and board of education committees know of our building inspection records, we are consulted frequently about such problems as ventilation, sanitation of toilets and locker rooms, and so on, with the view of modernizing the school equipment.

ABOUT THREE years ago, there developed among the physicians of the community and the county, an increased interest in school activities. This seemed to be the opportunity that our school had been looking for for years. A school health council was formed. The council received the backing and support of the Committee on Child and School Health of the County Medical Society, and the voluntary support and participation of the village physicians. Our school health council was the first one formed in the county, but within the past two years several other school communities have formed such groups, each one having its own characteristics to meet local needs.

As it now stands, the school health council

is made up of five general practitioners, the five pediatricians in town, the school physician, the school-nurse-teacher, a member of the board of education, a member of the PTA health committee, and the superintendent of schools who acts as chairman.

The role of the council is advisory. The group meets three or four times a year at the school to discuss health problems and policies. Some of the meetings are general in which a variety of matters are brought up, such as, germicidal lamps, physical examinations, advisable immunizations, et cetera. Other meetings are more specific and representatives from special allied or medical fields are invited.

Some of the ophthalmologists met with us to discuss our common problem of vision testing and reading problems and our mutual understanding on this subject has been most rewarding. At another time the dentists of the village and neighboring communities were invited to participate in a discussion of local dental policies, particularly in regard to fluorine treatment and school dental hygiene. Incidentally, this meeting was the first one most of the dentists could remember when so many of their local members had met to discuss a common interest. At another session, the physical education department joined the council in discussing the theories and purposes of its program. At another time, the guidance staff presented its program, and there was a marked indication of the interest that our local physicians have in mental health.

The results of the meetings of this constructive group have been most gratifying. A new feeling of friendliness now exists which links the school with the local professional group in a real spirit of cooperation. We now know that a school physician's advice to "talk with your doctor" regarding abnormal tonsils and the accompanying too frequent absences for sore throats is not interpreted as the school health department telling the family doctor what he should do for his patients. A standard form for reporting findings of health examinations by family physicians is in use for all school systems in the neighborhood. The doctors know what use is made of these reports and they are being returned with much more information than formerly. Whereas 10 percent of examinations of school children were formerly done outside of school, this year the percentage is between 50 and 60. The school physician is now released to do more constructive school work by conferences with parents, pupils and staff. There has been a marked decrease in the number of gym excuses since the doctors know that there is more to the physical education program than inter-scholastic sports.

To be a really working member of the school staff, the nurse must make her program flexible. Adjusting it to the pupil's schedule in order to interrupt classroom work as little as possible, is appreciated by the teachers. Then, when an emergency such as the county chest x-ray program makes interruptions necessary, the teachers accept the inconveniences. Parents also recognize our attempt to schedule all children of a family for physical examinations at one time. These careful schedulings, although time-consuming, pay large dividends in the cooperation which we receive from teachers and parents.

A school health service that is really accomplishing what the name implies cannot keep all of its activities enclosed within the walls of the health suite, nor on records carefully locked in the files. It must have a broad, flexible program which permeates through the entire school, entering such seemingly diverse fields of operation as guidance, physical education, community cooperation, building inspection, and health education. It must have as its principal interest the child, whose growing and enlarging personality needs the help and understanding of all with whom he must live, work and play.

INTERPRETATION OF PSYCHOLOGICAL EXAMINATIONS

HARRY V. BICE, PH.D.

ON FREQUENT occasions the author has asked a group of student nurses this question: "Suppose that in the course of your work with a child, you found occasion to request a psychological evaluation; just what would you expect to receive as a report of this examination?" The response most frequently given, and often the only one, has been, "An I.Q." In this article an effort is made to indicate some of the broader meanings of a psychological study of an individual and some significant elements to be found in a report.

There is no desire to take sides in the often debated question as to whether the nurse or the social case worker is the more appropriate person to make the interpretations to the family. We take as a starting point the conditions in which we have worked. More often than not, there has been no one but the nurse who could make any interpretation or explanation in addition to that made by the psychologist at the time of the examination. Frequently the nurse is in a strategic position. As public health nurse she may have been the first to realize the significance of a condition which the parents did not consider serious enough to refer to a physician. As nurse in the school she may have been the first to notice the symptom or defect which in due time resulted in medical examination and a request for psychological study. Often she has prepared the medical history and will later explain the physician's directions to the family and assist in carrying them out. If the nurse, in addition to all other information, knows the child as the psychologist sees him, she is better equipped to meet the needs of the child and the family.

In some cases an estimate of the intelligence level of the patient is requested. The easiest response the psychologist could make would be to determine the intelligence quotient and report it; this, however, would usually be inadequate and inaccurate. An intelligence quotient represents an average, and an average always tends to conceal variations. In a study of intelligence, the variations may represent special abilities and disabilities; they may indicate reasons for behavior that deviates from accepted standards; an emotional state that would prevent actual expression of one's potentialities may be discovered. Such points merit illustration.

L.A. was examined during her last year in high school where she was doing satisfactory work. In the course of the examination there appeared a combination of factors that should be known to any nurse who may make use of a psychologist's report. It would be literally true to say of L.A., "Her I.Q. is 67"; but there is something misleading in the statement. Obviously one does not expect a person with an I.Q. of 67 to be ready for graduation from high school and a complete report would explain this apparent inconsistency.

If only an intelligence quotient were reported, the nurse who received it should ask, "By the use of what test was this result reached?" With L.A., the Wechsler-Bellevue was used. Those who are acquainted with the field know this as an individual test which yields three I.Q.'s: one is based on verbal tests, one on performance tests, and one on a combination of the two. It was L.A.'s per-

Dr. Bice is a consulting psychologist with the State Crippled Children Commission of New Jersey.

formance scale I.Q. which was so low that, had it been reported as "the I.Q." one might wonder if she were feebleminded. Her verbal scale I.Q. was 107, a fact which gives a quite different notion of her ability.

IT APPEARS then, if a nurse is to interpret tests of general intelligence to parents or teachers, she should know something of the various tests that are employed, which are given to groups, which to individuals. She should know acceptable forms of reporting results. It is even more important that she should realize the significance of such variations as have been or will be indicated, since they are the rule rather than the exception.

To the initiated, the report of the examination of L.A. with the good work on verbal tests and very inferior accomplishment on performance tests suggests brain injury. She was particularly capable in tests of comprehension and similarities; but when she attempted to discover what parts of incomplete pictures were missing, she failed 9 of 15, overlooking some of the most obvious. One test was composed of three parts: a torso to which legs, arms and head were to be attached; a face and a hand each with six parts to be placed. She completed the first and placed four parts of the third correctly; she was unable to place a single part of the second. A child half her age should do better on two of the three items.

In the work of the New Jersey State Crippled Children Commission it is felt that the nurses can do better work if they are able under suitable conditions to observe the administration of a series of tests with different types of cases. They find few more surprising situations than those which occur when an individual does very well on certain tests but when asked to make a simple design of four blocks, is utterly confused. It is often these patients with conversational ability that is normal but specific shortcomings of a kind not usually observed in daily life who baffle many observers. They are often misjudged.

Just the opposite combination of abilities and disabilities may occur. E.R. has known nothing but failure in school. When he did not learn to read with his classmates, he was given special instruction. When this did not produce favorable results, he was transferred to another school where it was thought that some trying situation in relation to teachers or classroom was the cause of his trouble. Again, remedial measures did not bring the expected results. At 16 years he left school, still unable to read. Adequate motivation appears always to have been present, and still is. Often the parents find him at unexpected moments with open books before him, trying somehow to get meaning from the printed page.

This young man did very poorly on verbal tests; but when handling concrete materials, blocks that could be made into complicated patterns, formboards, puzzles, he did very well. He, though unable to complete the third grade, displayed abilities that L.A. the high school student did not possess.

Having demonstrated his excellent abilities in some problems, E. was asked to copy some words found in a standard vocabulary test. He wrote *apple* neatly, but did not know what he had written. He was shown the word *donkey* and seemed about to write it; but he stopped, pencil poised above the paper and said, "I forgot how to make *d*". He was told to print the word just as it appeared on the paper before him, and did so. Again urged to write it, he could not start. When told that the word was either *duck, David* or *donkey*, he thought it was *duck*.

Here the verbal test score alone would have inclined one to suspect feeblemindedness; but a feebleminded person should not be able to understand as readily as he did the total concept represented by the various separate pieces of material, or complete certain other tests so well. Further investigation assured us of the general social adequacy of the individual, again contra-indicating mental deficiency.

Since the intelligence quotient tells so little and can be so misleading, it is obvious that the nurse, or anyone else receiving the report of a psychological examination should have something more significant. At times we hear of an individual who is "referred for psychometric rating." Usually there is need of something more than the request implies. There is a wide range of cases in which under-

standing of the individual comes largely through means of investigation other than formal tests; and solutions of the problems involved require cooperation of the entire family of which the child is a part. While cerebral palsy cases are most often referred because of some problem related to their general intelligence, amputees, poliomyelitis, and rheumatic heart cases more often represent emotional problems.

Of these, we may consider briefly poliomyelitis, whose dark background is fear. When a parent reads the first disconcerting newspaper reports of the appearance of the disease, he experiences at least a fleeting unpleasant thought of what the summer holds for his child. If cases appear in his neighborhood, he is more concerned and begins to exercise suitable precautions. If his own child is taken ill, even before the doctor comes the parent is beginning to worry about crippling conditions and possible death. It may be a fear of the unknown. How often have we heard such a one say, "Look at the millions spent on polio, and they don't know anything about it yet." It may be born of ignorance, but it is fear.

The patients themselves may not share this fear. Some of the more marked and advanced stages of the disease may be reached without arousing this emotion in the child. Nevertheless, frightened parents can scarcely avoid communicating some uneasiness to the child. Emotion becomes more intense if the child must go to the hospital. In a typical case that came to our attention, a 7-year-old boy became a serious problem to hospital employees, not because of his illness, but his reaction to the total situation. He was given a test in which a series of pictures which lend themselves to many interpretations were shown him. He made up stories about them. He became so absorbed in the pictures that he soon shifted to use of the first person, indicating how certainly he was an actor in the scene. He told what separation from the family meant to him; he was deserted as he had never been before; he was fearful, in part because of the pain he suffered in examination and treatment but even more because of the vague uncertain things that might happen in the unwelcome environment. This is told, not to suggest that the nurse as a rule is unaware of the possibility of fears the child may have to contend with, but to show how one method of testing reveals the specific nature of the emotional experience.

The psychologist may again be called in after the child has returned home and is ready for school after a long period of care. How frequently the personality patterns have changed. The child who previously liked school and a generally active life, now wants no more of it. His every need has been served, often before he had opportunity to express it and he has enjoyed a greater measure of attention than ever was his lot before. These are very desirable experiences and many an older person has contrived means to continue them. No wonder the child does the same. Now the parents who over-protect the child, those who reject him, and those whose attitude toward him shifts with each passing thought must learn to know their changed child, and ways in which he can learn again to live the normal life. Understanding and guidance were never more important.

While something has been said about the significance of certain patterns of test performance, about different kinds of tests to be used according to the problem at hand, and about situations in which testing is at a minimum, a few words should be added about the part the nurse may play in the interpretation of a state that may complicate any disease or condition we have mentioned. We refer to feeblemindedness.

The nurse who is to plan with the parents for the education or placement of a mentally deficient child must recognize that she is not dealing with a disease. Parents who can accept an illness as an experience common to all families, find it difficult to believe that they have a child of subnormal mentality. It is a blow to their pride; they experience a sense of shame. Therefore they are often ready to reject a diagnosis of mental deficiency as soon as it is made, thus blocking all constructive efforts. Especially is this true if the parent does not understand the terms used.

One hears such defensive statements as this: "My child did not know the psychologist. He was frightened when he was taken into a strange room and asked questions. How could an examiner decide so quickly that he was feebleminded?" Sometimes this parental attitude would not have developed, had the psychologist been more skillful. He could have assured the parents that while he would learn something from his examination, they could tell him much more about the child's daily life. Then a series of questions, such as those in the Vineland Social Maturity Scale, could be asked; and the parent could be guided as he compares his child to normal standards and reaches a valid conclusion. Often such a conclusion is best stated in terms of the age of a normal child that the defective one resembles most.

Even if a parent observes the examination of his child, it does not follow that he understands in what manner the psychologist's conclusions were reached. If the nurse knows something of the process, she is in a better position to interpret. In one standard examination the way is carefully prepared before the child is asked for definitions. We consider here only three groups of tests arranged according to the age of the child, assuming that he has approximately the ability of a 4-year-old. He is shown single pictures and asked to name them; he is shown a group of pictures and asked to select certain ones according to their use; he is asked the purpose of houses and books and of what such articles as a chair or dress are made. Eventually he is asked to define certain words. The psychologist is interested in the answers to each of the questions asked; they reflect something of the reaction of the child to his environment. He is even more interested in the ability of the child to use the pertinent material that has but a few moments previously been recalled to his mind. If a child has been dealing in terms of *use, purpose, materials* of which a thing is made and does not use these cues in definitions, he is not doing as well as a child of four or five years should. If he is shown pictures among which is a stove and asked to point to the thing people cook on; and 10 minutes later is asked what a stove is and fails to note that it is something to cook on, he is not using very recent experience to solve a present problem. But a parent, observing an examination only hears the questions and answers, and fails to perceive their meaning.

IF A nurse has become acquainted with the significant factors in a test, she is more nearly ready to accept the conclusions herself and is to that extent prepared to interpret them to the family. In addition, she should know what the psychologist has said to the family. Then she must carefully determine the family feeling at the time of her visit: to what extent have they accepted the conclusions reached? In what terms have they been given the information? Are they ready for placement if the child must leave the home?

Too often parents are helped in accepting a conclusion about a child only to have all the groundwork destroyed later by thoughtless use of words. A visitor drove on the grounds of a training school where the author was employed and asked one of the mentally defective boys the name of the place. He replied, "F.M.I." as the school was popularly known; of course that was a reminder of the days when it was called the "Feebleminded Institute." The visitor then asked the meaning of the initials and received the reply, "Frankfort Military Institute." If the term *feebleminded* is difficult for a patient to accept, how much harder would it be for a normal parent? One does not ask for evasion with respect to an actual condition; but if it is easier for the parent to plan to send her "mentally deficient" child to a "state training school" why bludgeon her with terms that carry a less acceptable connotation?

The psychological examination, then, is a technic through which one may understand many aspects of an individual's life. Misunderstood, it falls short of yielding its full meaning; carelessly handled, it may defeat the very ends for which it was devised. But through skillful administration, and apt interpretation by both psychologist and nurse, it may contribute immeasurably to the adjustment of the child and his family.

THE SCHOOL DATA SURVEY

The Report of the Subcommittee on School Data Analysis, approved by the boards of directors of the six national nursing organizations, provides a general review of basic school facilities.

THE analysis of the School Data Survey, completed in mid-August, is being put to immediate use as the basis for a classification of the nation's schools of nursing. Known as the Interim Classification of Schools of Nursing Offering Basic Programs (1949), the classification has been approved by the boards of the six national nursing organizations.

The survey was made by the Subcommittee on School Data Analysis appointed by the National Committee for the Improvement of Nursing Services, a committee of the Joint Board of the Six National Nursing Organizations. The purpose of the study was to obtain a general review of basic school facilities—the source of the supply of the nation's nurses.

WHO PARTICIPATED IN THE SCHOOL DATA SURVEY?

Letters and questionnaires were sent to 1,215 schools of nursing in the United States, Hawaii, and Puerto Rico, in March 1949. It was found that twenty-five schools had closed since January of this year or were in the process of closing. Cooperation to encourage 1,195 existing schools to participate in the survey was solicited by letters and announcements sent to directors, hospital administrators, college or university presidents, and officers of local, state, and national nursing organizations. An announcement of the survey was also sent to allied professional groups and released to the general public. The amazing response from 96 percent of the total number of schools in the country is in itself an achievement of which the nursing profession can be very proud.

The number of schools in each state participating in the study of basic programs in nursing is indicated in the table on page 547.

WHAT SOURCES OF INFORMATION WERE USED?

Schools provided two sources of information (1) the data returned on questionnaires and (2) school bulletins and literature. In addition to the information received directly from the schools, other available and well recognized data were used. Supplementary materials included data on hospital facilities published by the American Hospital Association and the American Medical Association and on educational facilities published by the United States Office of Education.

The items on the questionnaire were selected after a series of study and work conferences. To make sure that the questionnaire would provide objective information about measurable aspects of basic programs, it was reviewed and tested by experts in nursing and general education. Some characteristics of schools were not measured because they are not amenable to this type of analysis.

An extra copy of the questionnaire was sent to each school for reference and file uses. Schools were given an opportunity to correct answers which were incomplete, unclear, or omitted.

School bulletins were carefully checked to verify and supplement information provided by the questionnaires.

Every effort was made to verify all data recorded. It is possible that some schools presented themselves in a too favorable light and that others did not give themselves full credit

for the quality of their programs. On the other hand, questions were included which permitted analysts to test the validity of the replies.

The data provided by each school pertain to the programs as of February 1949. By now, some schools may be providing additional fields of clinical experience for their students, may have expanded clinical facilities by new construction, may have added instructional personnel and revised school policies, or may have made other changes.

The committees believe that the findings are as accurate as is possible from this type of study, which is subject to human error and to omission of information regarding unmeasurable characteristics. The classification of the schools participating in this survey is presented not as final, but rather as a preliminary screening with the recommendation that it be reviewed within two years.

WHAT IS THE INTERIM CLASSIFICATION?

The Interim Classification of Schools of Nursing offering Basic Programs (1949) consists of two groupings into which schools have been placed according to their relative standings, based primarily on information submitted by the schools themselves. The upper 25 percent of all schools, based on the analysis of the school data, have been classed in Group I, the middle 50 percent in Group II. Each of these schools is identified as offering either a degree or a diploma program, or both. Not included in the classification are the remaining 25 percent of the schools—those in the low group, the schools which did not participate in the survey, and the schools which indicated their preference to be excluded from the classification.

HOW CAN THE CLASSIFICATION BE USED?

The initial purpose of the school data analysis is to provide information to be used in planning nursing education. In addition, the analysis, upon which the classification is based, includes a wealth of information on resources of nursing education facilities which will be invaluable in regional planning of nursing services. It will also be useful to community and state planning groups. No doubt the findings will be used as source materials for committees and special groups formed to study state facilities.

General statistical data, which does not in-

SCHOOLS TAKING PART IN THE 1949 STUDY OF BASIC PROGRAMS IN NURSING

States	Total number of schools	Number of schools participating	Number of schools not participating	Percent of schools participating
Total	1195	1152	43	96
Alabama	16	16	0	100
Arizona	5	4	1	80
Arkansas	8	8	0	100
California	40	39	1	98
Colorado	11	11	0	100
Connecticut	21	21	0	100
Delaware	7	7	0	100
District of Columbia	8	8	0	100
Florida	14	14	0	100
Georgia	14	12	2	86
Idaho	8	7	1	88
Illinois	86	74	12	86
Indiana	27	27	0	100
Iowa	26	26	0	100
Kansas	29	29	0	100
Kentucky	13	13	0	100
Louisiana	14	14	0	100
Maine	13	13	0	100
Maryland	22	22	0	100
Massachusetts	61	60	1	98
Michigan	26	26	0	100
Minnesota	27	27	0	100
Mississippi	20	20	0	100
Missouri	26	25	1	90
Montana	6	6	0	100
Nebraska	13	13	0	100
Nevada	—	—	—	—
New Hampshire	13	13	0	100
New Jersey	42	37	5	88
New Mexico	1	1	0	100
New York	114	110	4	96
North Carolina	40	40	0	100
North Dakota	10	9	1	90
Ohio	63	62	1	98
Oklahoma	12	12	0	100
Oregon	9	9	0	100
Pennsylvania	117	112	5	96
Rhode Island	6	6	0	100
South Carolina	17	16	1	94
South Dakota	7	7	0	100
Tennessee	16	16	0	100
Texas	34	32	2	94
Utah	8	8	0	100
Vermont	9	8	1	89
Virginia	34	33	1	97
Washington	21	21	0	100
West Virginia	24	23	1	96
Wisconsin	24	24	0	100
Wyoming	—	—	—	—
Hawaii	2	2	0	100
Puerto Rico	11	8	3	73

clude identification of the specific characteristics of individual schools, will be available to other professional groups. Already many requests have come to the committees for general information on schools of nursing, for descriptions of the survey methods, and for interpretation of the school data.

The classification will be useful to groups interested in the recruitment of more and better qualified students for future nursing services. For years counseling and guidance groups have asked the nursing profession for a classification of its basic programs. Prospective students in all regions will be helped by this listing.

WHEN WILL THE SCHOOL DATA AND CLASSIFICATION BE RELEASED?

By mid-September each of the 1,152 participating schools of nursing had received a confidential summary profile of its major characteristics as revealed in the questionnaire study, together with an explanatory letter. The summary profile indicated whether the school had been placed in the classification and, if so, in what group. It showed the school the relative standing of its basic program, and of some of the component factors which were measured in relation to the programs of all other schools. The relative national standings were indicated in quartiles (the highest 25 percent, the second 25 percent, the third 25 percent, and the lowest 25 percent of the participating schools). The component factors included in the profiles were student health, curriculum, clinical facilities and experience, library facilities, qualifications and size of teaching staff, and salaries of instructional staff.

Interpretation of the analysis of the school data, including tables on national and state and, in some instances, community resources, will be released in articles appearing in professional and lay publications. The names of the schools listed in the 1949 interim classification will be published in the November issue of the *American Journal of Nursing*. At the same time a composite description of the two groups will be given.

Information about the survey has been sent to all state nursing organizations for publication in their official bulletins.

WHO MADE THE SCHOOL DATA SURVEY?

Members of the Subcommittee on School Data Analysis, whose names are listed below, are experienced nurse educators who presented a wide geographic representation. They had the assistance of resource personnel from the nursing, medical, public health, and hospital professions, other allied educational, professional, and lay consultants, and a working staff.

Subcommittee on School Data Analysis

Louise Knapp (chairman), Dean, School of Nursing, Washington University, St. Louis, Missouri
Ruth Sleeper (alternate chairman), Director, School of Nursing, Massachuetts General Hospital, Boston, Massachusetts
Mary Brackett (secretary), Associate Director of Nursing Service, Hartford Hospital, Hartford, Connecticut
Flora D. Goode, formerly Nurse Education Consultant, Mississippi State Board of Nurse Examiners, Jackson, Mississippi
Lucy Harris, Director, School of Nursing, Harris Memorial Hospital, Fort Worth, Texas
Mrs. Estelle M. Osborne, Instructor, Department of Nursing Education, New York University, New York, New York
Sister Mary Geraldine, Dean, School of Nursing, St. Louis University, St. Louis, Missouri
Mrs. Elizabeth Soule, Dean, School of Nursing, University of Washington, Seattle.

Resource Personnel

Dr. Antonio Ciocco, Professor of Biostatistics, School of Public Health, University of Pittsburgh, and formerly Deputy Chief, Division of Public Health Methods, Public Health Service
Hazel Goff, Acting Director, National Nursing Accrediting Service
Elizabeth Kemble, Director, Department of Measurement and Guidance, National League of Nursing Education
Blanche Pfefferkorn, formerly Director, Department of Studies, National League of Nursing Education

Representative Consultants

Mrs. Frances Payne Bolton, lay representative
George Bugbee, hospital representative
Charles T. Dolezal, M.D., hospital representative
Thomas P. Murdock, M.D., medical representative
John Dale Russell, Ph.D., education representative

Working Staff

Margaret Baylous, writer
Mrs. Christy Hawkins, nurse consultant
Mrs. Margaret D. West, statistical analyst
Statistical and stenographic personnel

THANK YOU, MR. RAT

SUSAN E. KIESS, R.N.

"MY MOTHER couldn't make me eat this stuff when I was young," one twelve-year-old remarked to another as they ate whole wheat bread in the school cafeteria, "but I like it now. Don't you?"

"No!" her companion answered explosively. "I hate the man who invented cottage cheese and I don't like brown bread, but I know they're good for me and I eat them."

The sixth graders who made those statements were participants in a cou 'y-wide nutrition experiment conducted jointly in Lycoming County, Pennsylvania by the County School District and the State Nursing Service and Nutrition Division of the State Department of Health. The children's remarks were indicative of the response of hundreds of rural children taking part in the program.

Need for nutrition education in Lycoming County was evidenced by statistical reports of school medical examinations in the school year of 1946-1947. In a county justly proud of rich farms and lack of slum areas, 138 cases of malnutrition were found among pupils of fourth-class district schools. This figure represented one-half of the possible findings in the rural school population, since, in accordance with Pennsylvania's School Health Act, annual examinations are conducted only in alternate odd grades. It was logical, therefore, to presuppose an equal number of undernourished children among those not examined that year. In addition, the findings represented only vitamin and mineral deficiencies and gross deviations from normal weights. They were not inclusive of subclinical cases.

After consideration of the figures by Clarence McConnell, Lycoming County Superintendent of Schools, and the supervisor of the State Nursing Service which administers the rural school health program, it was felt that nutrition education on a county-wide basis rather than an approach to individual parents was indicated.

Health teaching is an integral part of rural school curricula and every good teacher attempts to incorporate nutrition as part of the syllabus. However, the average teacher has had little or no formal training in nutrition, and, particularly in rural schools, material on the subject is inadequate. Teachers complain, and with cause, that children are not interested because subject matter in health texts is drab and uninteresting and visual aids are rarely provided by school systems. They recognize the direct correlation between scholastic performance and nutrition; that for a child to progress normally in an academic program his body must be well nourished. They know that skills, attitudes and behavior are, to a great extent, dependent upon physical well being. Their difficulty lies in inability to stimulate children to appreciate these facts without visual aids and demonstrations. As a result of these factors, many teachers are frank in admitting their need for guidance and assistance in presenting nutrition programs.

With these facts in mind, Mr. McConnell asked the supervisor of the State Nursing Service to arrange programs for the health sessions of the annual County Teachers' Institute and for a project to be used in rural schools. The supervisor, in turn, appealed

Miss Kiess is county supervisor, Bureau of Public Health Nursing, Pennsylvania Department of Health.

to the State Health Department Division of Nutrition for assistance in establishing a program that, later, could be geared to different age levels for classroom presentation on a county-wide basis.

Dorothy Waller, the nutritionist assigned to the Institute by the Nutrition Division, conducted six sessions attended by public health nurses, dental hygienists and home economics teachers. Texts were built mainly upon the seven basic foods necessary for optimal health and the importance to the school child of nutritious breakfasts and lunches. Visual aids included posters, food models and a series of charts dealing with dietary experiments on albino rats, published by the Bureau of Home Economics and Human Nutrition.

These last were so graphic in portraying results of good and poor nutrition that the nurses decided to attempt animal experiments in schools where teachers and student bodies signified interest and willingness to cooperate. The animal projects were scheduled to follow a preliminary series of nutrition classes. Funds for the project were secured from the Lycoming County Community Chest and the Lycoming County Tuberculosis Society.

In the preliminary program, classes were conducted for eleven adult groups and in 57 schools throughout the County, with subject matter geared to the different age levels addressed. Visual aids included movies, slides, food demonstrations, posters, leaflets, colored books and charts. The Pennsylvania Department of Health and several cereal and dairy companies contributed literature to the extent that each teacher was provided with a kit that included a teaching manual in addition to the above aids. General Mills and the Ralston Company were especially generous with their educational materials. Each pupil was given pamphlets and attractive books with color prints to be taken home.

As a result of the ground work laid, 19 schools volunteered to try the animal experiment. Obviously, it would be impossible to attempt a truly scientific experiment in an environment so uncontrolled as the rural school. The objective of the experiment was to determine and prove to children the effects certain foods have upon the growth, appearance and general health of animals. It was hoped, of course, that their observations would affect their own food habits and have a carry-over into their homes.

The experiment lasted from 6 to 10 weeks. Two pairs of albino rats of the same sex, litter mates to insure the same genetic background and start in life, were placed in each participating school. Pupils assumed full care of the animals, cleaning the food cups and cages daily, and seeing that food and drink were constantly before the rats. For four weeks, one pair was fed a diet of ground whole wheat, powdered whole milk and salt, and water as a beverage. The other pair was given prepared corn cereal and sweet drinks. At the end of 4 weeks, these were switched to the wheat and milk.

Each rat was named, and, before a week had elapsed, each had become a personality to the children. That the children understood what they were attempting was shown by the names they chose, looking ahead to anticipated results. Dopey and Droopy, Boney and Tiny, and Skinny and Slim contrasted with Husky and Scamper, Snow White and White Satin and Lovely and Beauty. In a few instances a little difficulty arose because boys, in particular, were sympathetic and tried to slip a little wheat to the animals on the poor diet. Cage cards and graphs were kept to tabulate weekly weights and daily observations were made of physical differences.

Results throughout the county were fairly uniform. The rats on the whole wheat and milk diet gained rapidly. Their fur was sleek and smooth, eyes clear and bony structure good. Those on the prepared corn cereal and sweet drinks gained very little, had rough, mangy skin; sore feet; inflamed eyes and crooked bones. When, at the end of 4 weeks, these were given the wheat and milk, their improvement was spectacular. Girls and boys alike were quick to apply the results to their own and each other's appearances. Only one set of rats met with disaster. In one school, the rats were kept in the furnace room at night to guard against colds. One par-

ticularly cold afternoon, the children put the cages on top of the furnace to insure warmth overnight The next morning the rats were found very thoroughly roasted, and additional animals had to be bought for a classroom full of grieving children.

As experiments progressed, the children began to ask questions about the growth of grain and the food fed to dairy animals. These questions led the nurses to the county farm agent, and an additional program was arranged through the cooperation of the Lycoming County Agricultural Conservation Association and the Production and Marketing Administration. Representatives of these organizations conducted classes in each of the County's high and consolidated schools. Lessons dealt with the preparation and nutrition of soil through the growth and cultivation of grain and vegetables to the feeding of dairy cattle and milk pasteurization.

A film, "The Other Side of the Fence," borrowed from Production and Marketing, proved a particularly effective teaching vehicle in this part of the program. It demonstrated very graphically the effect of soil nutrition upon cattle, hogs and sheep, and the carry-over, into human nutrition, of well or poorly nourished animals through meat and milk. Animals in adjoining pastures were shown, with only a fence to separate well nourished soil and grass from neglected ground, where, although the grass looked all right, it lacked the minerals essential for good growth and health. The differences in the animals pictured were startling. The demonstration went on to show the effect that poorly nourished soil has upon grain and vegetables used for direct human consumption and the resultant effect upon human nutrition; that a carrot, for example, may look beautiful, but, if grown in deficient soil, lack many of the factors it should possess. Since Lycoming County is essentially rural, the farm agents felt that this project gave a definite lift to their own programs.

Through Mr. McConnell's efforts, teachers correlated the rat project with subjects other than health. The correlation was developed as follows:

Geography

Study of grain and dairy belts, citrus fruit areas and the cheese and dairy industries. Exports and imports.

History

Immigration. The parts played by peoples of various nationalities in the development of grain, vegetables and fruits, and settlement of new farm areas. Malnutrition as a result of war, blockades and drought.

Spelling

The use of new words such as vitamin, deficiency, nutrition, dietary, et cetera. In lower grades: gram, ounce, cage, et cetera.

Arithmetic

Addition and subtraction by computing weekly gains or losses in rats' weights. Total gains and losses. Percentages of gains or losses in weights. Division and multiplication by changing ounces to grams and vice versa.

English

Written themes and stories on the progress and actions of the rats. Essay contest.

Art

Posters and notebook covers. Cage covers, clay models of vegetables and fruit.

Public interest ran high. Three local newspapers carried periodic stories of the rats' development and the Associated Press picked up several items. Parents called the nurses for nutrition material. Parent-Teacher Associations and women's groups asked for classes. Inquiries were made about fertilization of small town gardens. Grocers complained that they were unable to supply the demand for brown bread and whole grain cereals. One nun in a participating parochial school remarked, "The Father complains that he can't get his brown bread unless he gets to the store very early in the morning." Milk sales in schools increased, and, most gratifying of all, teachers reported marked improvement in the quality of carried school lunches and a resultant improvement in many children's school progress.

Analysis of a questionnaire sent out to a limited number of homes and answered by 209 parents proved that the project had really affected many children's eating habits. Improvement was noted most in children's willingness to eat green and yellow vegetables, eggs, cheese and the whole grain breads and cereals. One child said, in the essay contest that closed the experiment, "I learned my lesson from the rats and I hope the other boys and girls do too before it is too late." An-

other wrote, "I think just watching the amazing differences in these rats should show anybody what a good diet can do for them; at least it showed all of us."

Colored as well as black and white pictures from which slides have been made were taken of the program, beginning with the teachers' institute and the planning conference and including growth and care of the rats in most of the 19 participating districts, field trips, from planting to the wheat harvest, and school lunches. Each of the eight staff nutritionists of the Division of Nutrition was provided with a set of the slides which have been used throughout Pennsylvania, in schools and at institutes and educational meetings. An exhibit and demonstration of the entire project formed part of a workshop in health education, conducted in July, at the Pennsylvania State College, and the exhibit was shown at over twenty county fairs. As a result, many school districts made requests for detailed information and assistance in promoting like projects. Staff nutritionists throughout the State have rendered this service. In Lycoming County the project was put on again, in the Fall term of 1948, and will be continued in the Fall term of 1949.

Educators and health authorities alike have expressed gratification at the results achieved. They are particularly pleased at the obvious carry-over into homes and the written comments of the children, many of whom brought their parents to school to make their own observations. As one child wrote at the close of her essay, "If all the mothers of growing children could have seen this experiment of these four rats, I believe that America would have healthy, growing children. Thank you, Mr. Rat."

WHITE HOUSE CONFERENCE—DECEMBER 1950

"To consider how we may develop in children the mental, educational and spiritual qualities essential to individual happiness and to responsible citizenship"—this is the purpose of the Midcentury White House Conference on Children and Youth as stated by a national committee of leading citizens. At an organization meeting in Washington, September 9, the committee set the week of December 3, 1950 as the date. At the same time they adopted five general objectives for the conference:

1. Bring together in usable form pertinent knowledge related to the development of children and indicate areas in which further knowledge is needed.
2. Examine the environment in which children are growing up with a view to determining its influence upon them.
3. Study ways in which the home, the school, the church, welfare agencies and other social institutions, individually and cooperatively, are serving the needs of children.
4. Formulate, through cooperative efforts of laymen and specialists, proposals for the improvement of parental, environmental and institutional influences on children.
5. Suggest means whereby these proposals may be communicated to the people and put into action. (See PHN, November 1948, page 566, for a resumé of early planning.)

Spadework for the forthcoming conference has been done over the past year and a half by several groups including the National Commission on Children and Youth, the Joint Interim Committee, the Federal Interdepartmental Committee on Children and Youth, and the planning bodies of nearly all the states and territories.

Immediate steps are now being taken to get preparations for the conference under way on a national scale. Governors are being supplied with information and suggestions for state and local participation. Letters are being sent to all organizations, public and private, concerned with children and youth, inviting their active participation in developing plans for the conference and follow-up programs.

The National Committee, appointed August 29 by the President, includes the chairman, Oscar R. Ewing, Federal Security Administrator, and more than 50 educators, labor leaders, physicians, clergymen, economists, and civic leaders. Katharine E. Faville, dean of the College of Nursing, Wayne University, Detroit, is the only nurse on the committee.

ANALYZING THE RESULTS OF THE COST STUDY

MARY ELIZABETH BAUHAN AND ELIZABETH C. STOBO, R.N.

WITH THE cost study nearing completion, the time has come to ask, "What do the results mean?" The studies of approximately 75 agencies have been under rather close scrutiny and are now about to be analyzed in detail for the final report. So much work, so many facts,—how are they to be made of more than academic interest? For the benefit of these agencies and any other agencies who may be interested in conducting studies according to this method, it seems timely to suggest some of the conclusions to be made by an agency after the long and in some respects arduous process. The 75 participating agencies will read this not only with understanding but also with deep down satisfaction in the light of their experience. It is hoped that agencies who have yet to do a study will find this exposition interesting now and helpful if and when they decide to make a study of their own.

COST STUDY METHOD IN BRIEF

Based upon a time study of the nursing staff, taken at a time when the operations of the agency are typical of the program, the cost study gets under way.

The greatest care should be taken in selecting the time study period since the purpose of the time study is to establish units of time for the various activities or cost centers for which costs are desired.

With the results of the time study tabulated according to the method, the next step is to apply the costs to these time units, with the end result that a cost is computed for each cost center and service selected for costing.

Careful statistical recording which produces accurate units for the number of visits, clinic sessions, and the like is essential to the validity of the results, as is an accurate record of the expenditures of the agency classified according to type.

Reference to Mabel Reid's article in the August 1948 PUBLIC HEALTH NURSING, "What Does Public Health Nursing Cost?" will be worthwhile for those wanting more details on method.

The Cost Study Manual, of course, is the guide for a cost study. The Manual will be available early in 1950.

AGENCIES PARTICIPATING IN THE STUDY

The 75 agencies mentioned are official, nonofficial, and combination in type. They are scattered over the United States with a concentration in the Middle Atlantic states. A picture of this distribution is shown in table below.

ANALYZING THE RESULTS

No one needs tell an agency that has gone through the throes of a cost study that the task has been a simple one. It is not an undertaking to be entered upon lightly. The most careful thought, planning, and instruction are required to begin with and the most meticulous checking of the results is essential. This latter point can hardly be overstressed. Results should always be viewed from the standpoint

Miss Stobo is director and Mrs. Bauhan, statistician, for the Study of Costs in Public Health Nursing.

of reasonableness, and must be done by a person with a thorough knowledge of the agency. In spite of these words of warning and caution, however, the cost study is a worth-while experience. Its results are concrete. Their application to the complex job of directing an agency and accomplishing the work to be done with a little better understanding of how it functions is readily seen. It helps remove the theory and guesswork under which any agency may function due to a lack of specific information and helps to put it on a business-like basis of operation.

REPORT OF 75 PARTICIPATING AGENCIES

Seventy-five agencies participated in the study by lending their material to NOPHN for analysis. The report will include exhibits, explanatory text and charts for portraying graphically the highlights of the findings. Its primary importance to participating agencies will be that it provides data with which the agency can compare its findings, by type of agency and size of nursing staff. These comparisons will cover unit costs of service, units of time, and expenditures by activities, by operations, and so on. Averages and percentages will be used mainly as the means of making possible these comparisons. However, use will also be made of the distribution of the agencies themselves to show the concentration in a particular item.

While comparisons have their place and use in this kind of undertaking, they should be made with a definite understanding of their limitations. It is true that a standard method of computing costs has been developed and used as far as this study is concerned, but there are many factors which introduce variables. Without a knowledge of another agency's program it is possible to make unsound deductions. This will be stressed when the report is released and should be borne in mind as results are reviewed.

Aside from their comparative value, the results will be of great interest to all in the nursing field as they reflect the actual costs of service and the time needed to do the nursing job. Here for the first time is information on refinements of service that have heretofore been known in only isolated instances in which special studies have been made for a specific purpose.

STUDY OF ONE AGENCY

What must be available to make the study has been discussed under *Method*. When the study is completed one is faced with a formidable amount of material which may be rather overwhelming if viewed in the mass.

Unit time and cost of various services. Probably 99 percent of all directors will turn to this exhibit which gives the cost per visit by type. Here is an interesting exposition of the whole gamut of visiting and must be very gratifying to the person who has always known that the noncommunicable disease visit was more costly because of its length, but, through lack of information, was never quite sure how the cost varied due to the length of the visit. When this group is subdivided into such diagnoses as cancer, chronic, and others, costs become even more significant. Variations in the amount of time it takes to give the nursing service needed help explain better than any other single factor the cost of service.

Just as interesting as the visit data are

	Total	Official	Nonofficial	Combination
Total agencies participating	75	16	50	9
New England	10	—	9	1
Middle Atlantic	31	6	21	4
East North Central	13	—	11	2
West North Central	6	3	2	1
South Atlantic	8	3	4	1
East South Central	1	1	—	—
West South Central	1	—	1	—
Mountain	3	3	—	—
Pacific	2	—	2	—

the time and cost units for nursing service in clinics for those agencies which provide this service. The variation here among clinics is large according to the type of clinic and the number of nurses needed to staff it. Preparation and post-activity time as it relates to the actual time of the clinic session will explain the amount of time needed to do this phase of the agency's work.

Such programs as visits to school buildings, classes for group teaching, and health conferences staffed by nurses without a physician present are a few of the many cost centers for which detailed information on time and costs may be collected.

It would be overlooking an enormously large amount of significant material to let interest in the cost study stop with the examination of unit time and cost data.

Expenditures and their distribution. In preparing expenditure data so that unit cost may be computed, much valuable knowledge is gained about the working of the agency. To set up a cost for each activity or cost center, it is necessary to ascertain the operational charge for various items. For example, expenditures relating to staff nurse work are found by application of the rate per hour of staff nurse time to the hours spent by the staff nurse in nursing activities. Supervisors' and specialists' work requiring special qualifications is likewise charged off at the individual's rate per hour. A charge per hour is computed for supervision, for overhead, transportation, and other operations. These rates in themselves are significant and revealing. Furthermore, when total expenditures are subdivided according to these rates, a simple percentage distribution, showing the extent to which each operation (staff nurse work, supervision, overhead, transportation, et cetera) contributes to the whole is of immeasurable value in budget-making and efficient administration.

Finally, a distribution of expenditures into activities or cost centers is arrived at with each factor mentioned above charged off according to its rate. Here again a percentage distribution helps to focus attention on weight of each activity in the total picture. This is definite information for the agency to use in agency and community planning.

Time and its distribution. The saying, time is of the essence, was never applied to any undertaking more truly than to public health nursing. Therefore, it is important to see what use is being made of this important commodity. To distribute costs over various activities the time spent in these activities must be obtained. This means that, in addition to knowing how much it costs to conduct the service of the agency, we also know how much time is required. Resorting again to percentages which are easily understood and a means of relating items to each other, the time-demands of the various activities of the nursing staff are placed in proper perspective. These percentages help the director to see whether or not a program is out of line in relation to the problem in the community for which it is maintained. This applies not only to nursing services to patients, but to other programs aimed to enrich the agency's service or to further the work of public health nursing.

Distribution of time to a service is made up of preparation or post-activity time, time spent in the activity itself, and travel time. These components are very significant in handling the time problem inherent in nursing work.

All time calculations should be used only as they relate to the broad aspects of the agency's work. In the interest of accurate recording during the time study periods, no use should be made of the results for supervisory purposes.

THE COMPLETE PICTURE OF A SPECIAL SERVICE

If an agency works in a particular field because of community needs, it may provide service through several channels. Nursing service may be given in a clinic and nurses may make visits to the home. Because of the degree of refinement possible through this method, related cost centers may be added together. In the tuberculosis program the cost of nursing service in a tuberculosis clinic may be added to the cost of all home visits to tuberculosis patients and their contacts, to

ascertain the total cost of nursing work in this area.

The agency that has a student program will be interested in the cost of the entire program, the cost in relation to the various levels of students assigned to field work, the amount of time various members of the nursing staff spend on the program, the amount of time that the student spends in replacing a staff nurse, and the manner in which this replacement time reflects the cost to the agency for each type of student.

WHAT TO CHARGE FOR NURSING SERVICE

One reason for doing a cost study is to determine a charge for nursing service. It must be remembered that the purpose of this study is to find out the actual *cost* of nursing service in the community served by the agency. There may be—and undoubtedly are—factors which may influence the *charge* made for this service. In arriving at a charge which seems just, it is sound in making agreements with consumers to start from the standpoint of what the nursing service actually costs.

HEALTH READERS FOR SCHOOLS

For about a decade the Project in Applied Economics, sponsored by the American Association of Teachers Colleges and financed by the Alfred P. Sloan Foundation, has been working to demonstrate how schools can help improve clothing, housing, diet and health in the communities they serve.

As a part of this work the Project has published a number of health readers which should be of particular interest to public health nurses who visit schools. Working with teachers, public health nurses can use these booklets as tools for the effective teaching of better health. They are designed to supplement text-books, and contain information covered by text-books only in a general way, if at all. All of them are written by teachers and of course carefully checked for accuracy by health authorities.

Five of these booklets, all of them illustrated and written in narrative form for children, will be helpful in the daily work of the public health nurse.

Roddy the Rat (72 pages, 15 cents) is a story of the spread of typhus fever and of ways of getting rid of rats, written for the intermediate and secondary grades. It concerns Roddy, an ambitious rat and the damage he does to man, and is read eagerly by the children who have seen it. In it are facts about typhus fever, directions for rat-proofing houses and methods of getting rid of rats in barns, city basements or wherever else they may occur.

Pineville High Meets the Challenge (54 pages, 15 cents) is about hookworm. The football team is discouraged and listless because so many of its members have the disease. The story tells how they carry on a successful campaign to eradicate hookworm and contains the facts necessary for any school to learn about the disease.

The Case of the Whispering Class (56 pages, 15 cents) for secondary grades, is about personal cleanliness. In a way which cannot give offense, the booklet tells how a teacher and her class worked out clues to personal cleanliness at school, at home, on the playground, and on the job.

The Story of Johnny and Mary (40 pages, 15 cents) is about diet for grades five through nine. It helps children find out what they actually do eat and compare that with what they should eat, and tells why they should not only eat, but like, the proper foods.

Jack's Secret (67 pages, 15 cents) is about tuberculosis, for intermediate and secondary grades. It gives all the facts, in addition to being an interesting story to read, and has been used extensively by tuberculosis and health associations in various parts of the country.

Public health nurses will find it worth while to get these booklets, show them to the teachers they work with, and decide with these teachers the most effective ways of using them. They are sold at or below printing cost and can be obtained from the Project in Applied Economics, P. K. Yonge Building, University of Florida, Gainesville, Florida.

TAX FUNDS IN NONOFFICIAL AGENCIES

DOROTHY E. WIESNER AND SYLVIA WEISSMAN
NOPHN Statistical Service

THE 1948 Yearly Review provided detailed information about incomes in nonofficial agencies,* and the use of tax funds in these agencies has been separately studied.

Three aspects of the use of tax funds in nonofficial agencies seem worth reporting to readers of the magazine. One of these is the kinds of official departments appropriating tax funds; the second is the purpose of the appropriations; and the third, the bases of the appropriations. Usable material on tax funds was secured from 219 nonofficial agencies, for the most part visiting nurse associations. Almost 80 percent of the 219 agencies received tax funds from one or more sources.

The most usual unit of government reported was the local city or township; 129 agencies reported appropriations from such sources. Seventy-nine agencies reported money from state governmental units, 48 from county units, and 14 from federal units. Some agencies were paid by more than one governmental unit.

Welfare and relief official departments were more frequently noted than were any other departments; 86 agencies reported receiving such appropriations. Not included in these 86 were payments from Social Security departments, including old-age assistance, crippled children service, aid to the blind, and the like, which were noted by 35 agencies—Emergency Maternal and Infant Care payments were mentioned by 37 agencies. Six agencies received money from the Veterans Administration.

Health departments appropriated tax funds to 45 nonofficial agencies, and boards of education to 25 agencies. Other types of official departments reported as appropriating tax funds to nonofficial agencies were Rehabilitation Service, a county park commission, city physicians, and county and state hospitals. Fifty-eight agencies did not specify the department of the local or county government units which made the appropriations.

The following suggestions were listed on the Yearly Review schedule under "purposes":—general, acute communicable disease, bedside care, infant and preschool, antepartal, delivery, postpartal, physical therapy, rehabilitation, school, tuberculosis, other.

Some tax appropriations covered work in more than one of the above fields. On those schedules on which *general* plus two or more other items were checked, the appropriation was tabulated as being for "general" purposes, and the individual purposes were not counted. Proceeding on this plan, we noted 436 statements of purpose, of which 102 were for bedside care, and 101 for "general" work of the agency. Maternity nursing was next as to frequency,—52 instances for postpartal, 37 for antepartal, and 8 for delivery nursing being reported. School nursing was indicated 37 times, infant and preschool health service 31 times, acute communicable disease nursing 17 times, and service to crippled children 14 times. Other physical therapy was indicated 4 times. Tuberculosis was checked only 9 times. Other purposes were written in, and included rehabilitation, camp nursing, alien citizens' aid, venereal disease nursing, nursing service in immunization clinics, and rental of rooms to a health department for clinic service.

The basis of tax fund payment most often reported was per visit, and this was reported 173 times. Next as to frequency was "lump sum", reported 86 times. Payments for

* For analysis of income and expenditure data, see PUBLIC HEALTH NURSING, May 1949, page 244.

TABLE 1. CHANGES IN NUMBER OF VNA'S[a] RECEIVING TAX FUNDS

Types of official departments	Number of VNA's receiving tax funds 1947	1939
Agencies receiving tax funds from welfare and allied departments	86[b]	55
Agencies receiving tax funds from health departments	45	53
Agencies receiving tax funds from boards of education	25	23

[a] The sample varied somewhat from 1939 to 1947; in 1939 data were secured from 206 agencies, and in 1947, from 219.

[b] Does not include Social Security agencies nor EMIC.

nurses' salaries were reported 25 times; time bases, such as per hour or per day, 18 times; use of office space in public building, 15 times. Other more unusual bases were per capita or per class enrollment for school nursing; money or bus fares appropriated for transportation; and appropriations on the basis of the number of clinics or conferences attended by a nurse.

The use of visiting nurse associations by official welfare departments for nursing service for their clients is now customary. This has become more prevalent since the time of the last report about tax funds in nonofficial agencies,* largely because of the increase in the number of official departments dealing with relief and allied problems. Less change was found from 1939 to 1947 as to the number of health departments and boards of education appropriating money than in welfare and relief departments.

* Wiesner, Dorothy E. Tax funds for nonofficial agencies. PUBLIC HEALTH NURSING, v. 33, February 1941, p. 111.

The payment of tax funds to nonofficial agencies on the visit basis is part of the picture of bedside care done by the agencies. New cost studies may raise decidedly the amount to be charged per visit. In the trial period of supplying service to an official department, appropriations on visit or time basis are usually preferred. This necessitates detailed billing. Lump sum appropriations save detailed billing and allow the nonofficial agency to budget more accurately. We should like to hear from some interested administrators as to the good and bad points in lump sum appropriations.

In the sample of 206 nonofficial agencies in the 1939 study, 147 reported tax funds appropriations and the total amount received was $580,805. In this 1947 study of 219 agencies, 175 agencies had appropriations of $680,190. Table 2 below shows the 1947 amounts by types of official departments appropriating tax funds, and the greatest and smallest amounts of money received by any one agency reporting such appropriations.

TABLE 2. MONEY RECEIVED BY VNA'S FROM OFFICIAL DEPARTMENTS, 1947

Departments appropriating tax funds	Number of instances	Amounts of money appropriated	Percent of total	Ranges of amounts of money received	
				Greatest	Smallest
Total instances	321	$680,190[a]	100.0	$40,800	$ 4
Welfare and relief	86	231,065	34.0	40,800	8
EMIC	37	8,594	1.3	1,830	4
Veterans Bureau	6	746	0.1	348	5
Social Security	35	34,769	5.1	6,063	19
Health departments	45	132,867	19.5	11,700	39
Boards of education	25	36,976	5.4	12,689	41
Boards of supervisors, etc.	9	22,196	3.3	6,000	271
All others	18	42,842	6.3	20,000	5
County and local government, department not stated	58	166,805	24.5	14,527	9
Government and department not stated	2	3,330	0.5	2,700	630

[a] This total is not the same as the total of tax funds on the Income study in the May issue of PUBLIC HEALTH NURSING, as some additional agencies are included in the above table.

TRENDS IN MEDICINE AND PUBLIC HEALTH

RUBELLA AS A CAUSE OF CONGENITAL DEFECTS

What percentage of mothers acquiring rubella (German measles) during pregnancy give birth to children with congenital defects? Drs. Stuart Abel and Theodore Van Dellen have reported in a preliminary way on this question in the August 13, 1949 *Journal of the* AMA.

In 1941 a study made in Australia for the first time suggested that there was a relationship between maternal rubella and congenital defects in the child. Subsequent observations have appeared to strengthen the original thesis.

The present study was made in the hope that the accumulated data might be helpful as an index of the numerical probability of congenital defects in children born of mothers who had rubella during pregnancy. These women were approached through the facilities of a syndicated health column. They were asked to indicate the period of gestation in which the ailment was acquired and the outcome relative to the child. Eighty-two letters concerning 84 children were received and analyzed.

Eighty-seven percent of babies born of mothers having rubella in the first trimester were abnormal, 42 percent in the second, and probably none in the third. The principal anomalies noted were congenital heart disease 19, congenital cataracts 17, deafness 14, mental deficiency 7, and malformed teeth 5.

The disadvantages and inaccuracies of the method and the data are admitted but the high percentage of abnormalities in children whose mothers had rubella in the first trimester is significant of a correlation between congenital defects and maternal rubella.

The advisability of therapeutic abortion is raised. As yet no hard and fast rule can be made, and this important decision still awaits additional critical study. It is believed that all prospective parents should be acquainted with the background of the problem and given an opportunity to share in a decision.

CANCER SOCIETY AIDS IN NURSING COSTS

A plan for the reimbursement of nursing agencies in Connecticut for cancer bedside nursing not otherwise paid for was initiated on September 1, 1947 by the Connecticut Cancer Society. Edwin R. Meiss in the December 1948 *Connecticut State Medical Journal* reports on the first-year results.

The aim of the plan was to enable nursing agencies to increase their care in the home despite mounting budget costs, payment being on a per visit basis. It was hoped that by increasing bedside nursing visits the family of the cancer patient might have its situation eased and in many cases the patient might be kept at home rather than institutionalized. It was also expected that the visiting nurse would continue to improve her alertness to possible cancer symptoms and be the agent for the Society's educational function to promote early diagnosis.

In one year the total number of visits reported by 54 public health nursing agencies was 19,268 (1,257 cases) and the total cost to the agencies was $27,250. The agencies received specific payment from other sources in the amount of $10,660 and the CCS paid a total of $16,590 as the balance of the cost of these visits. Added to this, CCS paid the agencies $1,195 for nursing service rendered in Tumor Clinics. The total paid by CCS represented 66 percent of the visiting nurse cost of cancer service.

The Connecticut Cancer Society has set aside $16,000 to continue the reimbursement plan for the current fiscal year. The plan is

to be continued without change, although experience may confront the Society with the necessity of adjusting the plan to the funds available.

WHAT ABOUT SEASICKNESS?

Ignorance of the cause and cure of seasickness has, until a few years ago, acted as a spur to speculation and a variety of new drugs have been offered for treatment. Adequate testing of these drugs was made possible during the war. Recent findings have been published in the May 14, 1949 *Lancet*, an English publication.

In tests made in 1944 it was shown that of a number of remedies tested, only those containing belladonna alkaloids had any significant effect, and that of these, hyoscine was the most satisfactory. When given in a dose (0.6 mg) that led to negligible side effects, it prevented over half of cases of motion sickness.

Gay and Carliner of Baltimore have evolved a new treatment—"Dramamine"—which appears to be effective both in prophylaxis and cure. This new drug belongs to the antihistamine group of compounds which had not previously been used in the therapy of motion sickness.

In a study of the effects of dramamine on seasickness, using 485 soldiers for the special observation on an ocean voyage which happened to be particularly rough, dramamine was given to 134 of them every 5 hours and just prior to retiring for the night. Of this number only 2 became seasick, whereas of the 123 who were given a placebo of lactose 35 were sick. In treatment, the drug is no less effective: of 228 men who received no prophylactic dose, 48 became sick; 15 of these were given dramamine, of which 14 recovered within one-half hour. Of the control group of 33 who received a placebo, no fewer than 19 recovered within 12 hours and needed no further treatment for the remainder of the trip, their recovery presumably due to their normal adaptation to ship motion. In all, 300 cases were treated and complete relief within an hour or less was obtained in 96 percent of the cases.

HICCUP REMEDIES

Over 200 different treatments have been proposed for the curing of hiccups, according to an article in the *Lancet* of May 14, 1949. Common therapy—a sudden surprise slap on the back, holding the breath, deep breathing, traction on the tongue, inhaling smelling salts, drinking neat whiskey, tickling the nares, et cetera—is often as effective as any for the occasional hiccup. When a gastric cause is suspected, alkalis, aromatic oils, and carminatives may be tried, and occasionally aspiration or lavage of the stomach or induction of vomiting. With the distressing postoperative hiccup when action is imperative, the usual measures often disappoint. Instead, bromides, barbiturates, opium derivatives, hyoscine, and general anesthesia have been recommended. Other treatments have included administration of intravenous fluids, antispasmodics, amphetamine, and quinidine.

The possibility of treatment by interrupting the phrenic nerve was recognized more than a century ago. In 1833, Shortt of Edinburgh succeeded in 2 cases by blistering the surface of the neck over the origin and course of the nerve, and his review shows how little has been added to our knowledge since his day. Since then interruption of the nerve has been achieved in various other ways.

NEW BOOKS
AND OTHER PUBLICATIONS

NURSING OF THE SICK—1893

By Isabel A. Hampton et al. New York, McGraw-Hill, 1949. 218 p. $3.50.

Nursing of the Sick—1893 is, what the title does not indicate, a collection of the papers about nursing and its problems which were presented at the International Congress of Charities, Correction, and Philanthropy held in Chicago in 1893. This was the first public appearance of Nursing.

The reader might well ask: "What were the problems of nurses in 1893? Who were thinking about and acting toward their solution? What relationship exists between the nursing problems of 1893 and 1949?" Let us brouse through the papers. Isabel A. Hampton was concerned about The Educational Standards for Nurses. Florence Nightingale discussed nursing education in a very spicy paper Sick Nursing and Health Nursing. Lavinia Dock defined The Relationship of Training Schools to Hospitals. Edith A. Draper discussed the Necessity of An American Nurses' Association. L. M. Gordon described The Royal National Pension Fund for Nurses. The problems of the Association for the Training of Attendants were presented by Mrs. D. H. Kenny. The problems here represented are nursing education, the organization of nurses, economic security, and nurse's aides. Sounds like 1949 to me!

This just skims the top of famous names of nurse pioneers whose papers are included in this invaluable collection. Papers about nursing in Germany, France, Switzerland, Scotland, England are to be found. The student of nursing history finds in this volume, a gold mine of easily accessible, fascinating primary source material. It is an exciting book for any nurse to ramble through.

—Miss H. Rosalind MacLean, *205 E. 72 Street, New York 21, N. Y.*

THE FAMILY OF TOMORROW

By Carle Zimmerman. New York, Harper and Brothers, 1949. 256 p. $6.00.

This small but dynamic volume is an attempt by a prominent American sociologist to come down from sociological ivory towers and take the case of the allegedly disintegrating American family system to the public-at-large. The author of the book feels that unless present family pattern trends are changed our whole American civilization may go the way of ancient Greece and Rome.

Dr. Zimmerman believes that family patterns follow something of a cycle, and he outlines with considerable skill his concept of these chain family reaction patterns in the Western World since 1500 B.C. According to Dr. Zimmerman the full swing of this chain reaction cycle from integration to disintegration has occurred several times in the past thirty-five hundred years. He believes that our American family system of today has reached the stage of a cycle which is characterized by weakness and decay. However, Dr. Zimmerman is not a fatalistic determinist and believes that this trend toward disorganization can be halted through reverting to an earlier family structure where basic family values are re-created. This, he feels, can be achieved through the establishment of an American Family Institute which he envisages "will attempt to do for the family what the Farm Bureau Federation and the Farmers' Union do for agriculture, what the American Federation of Labor and the CIO do for labor, and the American Chamber of Commerce and the American Manufacturers' Association do for business.

In summary, this is a challenging and highly stimulating book, and, while one might disagree with individual aspects of the analysis and projected ways out, one cannot deny

that it focuses attention on one of the most vital issues facing the Twentieth Century USA.

—T. P. YEATMAN, *Ass't. Professor of Sociology, George Peabody College for Teachers, Nashville, Tennessee.*

PSYCHOSOCIAL DEVELOPMENT OF CHILDREN

By Irene M. Josselyn. New York, Family Service Association of America, 1948. 134 p. $1.75.

Dr. Josselyn has well summarized the psychoanalyst's view of children's psychological development in a little volume that is brief yet comprehensive. Her hope that she may make her psychiatric concepts available in "direct, pertinent, and unambiguous statements" has been well achieved. The book represents a syllabus of lectures planned for professional social workers who may be expected to be at home with the psychoanalytic terminology which is employed and adequately explained in the text.

An introductory chapter emphasizes the fact that every child develops not only as an individual but also as a member of society. Personal drives and capacities together with social forces influence the behavior and modify the achievements of the developing child. Knowledge concerning factors from both sources is essential to an understanding of human mental growth. The elementary components of the human personality—id, ego, and super-ego—are briefly and clearly described and their inter-relationships discussed in terms of optimal conditions for satisfactory personality development. Infancy, the training period, the oedipal period, the latency period, and adolescence are discussed in sequence, each being the subject of a short chapter. In a concluding discussion of the caseworker as a therapist Dr. Josselyn points out numerous ways in which the role may be successfully played by the worker who adequately understands the psychosocial development of children. Nine pages of bibliography, arranged in reference to the chapters dealing with child development, as well as under the headings of psychotherapy and psychiatric and psychoanalytic theory, form a valuable appendix.

The author clarifies her various points with a wealth of illustrative case material presented in a lucid manner which is always instructive and frequently entertaining. Her discussions and illustrations pertaining to infancy and early childhood seem more direct and less involved than those in the chapter on adolescence.

Psychoanalysis has contributed so much to our understanding of the dynamics of children's behavior that all who work professionally with children—physicians, nurses, social workers, psychologists, teachers—should be somewhat acquainted with its teachings, whether or not they are able to accept them wholeheartedly. With the incorporation of psychological and mental hygiene concepts into many fields wherein the public health nurse has long been a vitally important coworker, her need for some psychoanalytic orientation is obvious. Dr. Josselyn's book may be enthusiastically recommended as an early reference and convenient source of review for the public health nurse who seeks this orientation.

—CHARLES BRADLEY, *M.D., Associate Professor of Pediatrics and Psychiatry, University of Oregon Medical School.*

SYMPOSIUM ON MEDICOLEGAL PROBLEMS

Edited by Samuel A. Levinson. Series 2. Philadelphia, J. B. Lippincott, 1949. 276 p. $5.00.

Any nurse who desires to know how to determine the age, sex, race, and height of a dead human body by examination of a few available bones will find useful material in this book. The subject matter consists of five medicolegal essays, presented in each instance by a qualified physician and an attorney, followed by a question and answer period, which is more or less fully reported. In addition to the legal aspects of the human skeleton, other topics include psychiatry in the civil and criminal law, respectively; federal control of drugs and cosmetics; and radiation hazards and health protection in radioactive substances, with some provocative comments on the atom bomb. Those who are interested in or concerned with these im-

portant subjects will find much of value in this well printed book.

—James A. Tobey, *M.D., 840 Forest Avenue, Rye, N. Y.*

FETAL AND NEONATAL DEATH

By Edith L. Potter and Fred L. Adair. Revised edition. Chicago, The University of Chicago Press, 1949. 173 p. $3.75.

This is the second edition of a very useful and widely read book, first published in 1939. The original intent of the book was to create interest in the problems of stillbirths and deaths of infants in the early days of life. There has been a marked reduction in stillbirths and deaths under one month of age, but interest in pregnant women and their newly born infants continues unabated.

The present volume is much like the first edition. The first chapter is devoted to a description of the normal infant. Autopsy technic applicable to the newborn is described in the next chapter. Chapter III is a survey of the principal causes of fetal and neonatal deaths. Special pathologic conditions are discussed in detail in the following chapter. A concise description of erythroblastosis is included. The malformations which may result from maternal German measles are described. The last chapter provides statistical data pertaining to births, maternal and infant deaths and stillbirths in the United States and at the Chicago Lying-in Hospital, illustrated by charts and tables. Many excellent illustrations help to clarify the text.

This book will be extremely useful to anyone interested in maternal and child health, specialists in obstetrics, pediatrics or pathology, students and other workers in this special field.

—M. Edward Davis, *M.D., Professor of Obstetrics and Gynecology, University of Chicago.*

ADMINISTRATION

Public Health Nursing in Los Angeles County. Volume I. Research Department, Welfare Council of Metropolitan Los Angeles. 1949. 115 p. $2.00. Loan copy available from the NOPHN office for 25c to cover cost of mailing.

GENERAL

Medicine of the Year. By Hugh J. Morgan, Frank Whitacre, Henry G. Poncher, Warren H. Cole. First issue. Philadelphia, J. B. Lippincott. 1949. 143 p. $5.00.

Ward Administration. By Margaret Randall. Philadelphia, W. B. Saunders. 1949. 326 p. $4.00.

A Review of Nursing. By Helen F. Hansen. 6th ed. Philadelphia, W. B. Saunders. 1949. 866 p. $4.25.

Introduction to Microorganisms. By LaVerne Ruth Thompson. 2nd. ed. Philadelphia, W. B. Saunders. 1949. 454 p. $4.25.

Ward Administration and Clinical Teaching. By Florence M. Gipe and Gladys Sellew. St. Louis, C. V. Mosby. 1949. 357 p. $4.25.

Mosby's Comprehensive Review of Nursing. St. Louis, C. V. Mosby. 1949. 704 p. $5.75.

Thank God for My Heart Attack. By Charles Yale Harrison. New York, Henry Holt and Company. 1949. 144 p. $2.50.

The Effect of Experience on Nursing Achievement. By R. Louise McManus. New York, Bureau of Publications, Teachers College, Columbia University. 1949. 64 p. $2.10.

Reminiscences of America's First Trained Nurse. By Linda Richards. Philadelphia, J. B. Lippincott. 1949. 121 p. $2.00.
A reproduction of the original (1911) edition.

Medical Etymology. By O. H. Perry Pepper. Philadelphia, W. B. Saunders. 1949. 263 p. $5.50.

SCHOOL HEALTH

Our School Studies. Annual Report of the Profession to the Public. By the Executive Secretary of The National Education Association of the United States, 1201 Sixteenth Street, N. W., Washington 6, D. C. 1948. 15 p.

TUBERCULOSIS NURSING

Instructional Plan for Basic Tuberculosis Nursing. Prepared by the Subcommittee on Tuberculosis Nursing of the Committee on Curriculum. National League of Nursing Education, 1790 Broadway, N. Y. 1949. 58 p. $1.00.

Safer Ways in Nursing to Protect Against Tuberculosis. Prepared by the Joint Tuberculosis Advisory Service of the NLNE, NOPHN, NTA. 1948. 108 p.
May be secured through local and state tuberculosis associations.

FROM NOPHN HEADQUARTERS

FINAL STRUCTURE REPORT IN PROSPECT

Hortense Hilbert, chairman since November 1946 of the Committee on the Structure of National Nursing Organizations, has accepted appointment, offered by the Executive Committee of that group, as nurse consultant to the Committee during the months of October and November. Her first responsibility will be meeting as many as possible of the requests already received from state groups for speakers on structure at autumn meetings. In addition, she will conduct the analysis of the "opinionnaries" now reaching the Committee from nurses all over the country. This analysis will provide the basis for the final report of the Committee on Structure.

"December 1 is the latest date for receipt of opinion sheets from the field," said Miss Hilbert, "but we hope that a major portion of them will be in hand much earlier. These sheets, to be reproduced from the forms offered on pages 17, 26, 36, and 37 of the 1949 Handbook and filled in by either groups or individuals, are the means offered by the Committee to all nurses for democratic participation in formulating whatever proposals are to be brought before the six participating organizations for vote presumably at the time of the 1950 Biennial. The Committee hopes that a very large number of nurses will wish to express their opinions on the two forms of organization that are being considered."

Five thousand additional 1949 Handbooks have been secured by the Committee on Structure to supplement the 20,000 originally printed. The new supply should make it possible to fill requests through the autumn. Single copies are sent free on request made to the Committee on Structure, Room 209, 250 W. 57th St., New York 19. Requests for quantities should be accompanied by an explanation of how the materials are to be used and number in the group among whom they are to be distributed.

To supplement the limited Handbook supply, reprints of "The Structure Study," the abbreviation of Handbook material printed in the *American Journal of Nursing* of April 1949, have been secured. Copies may be had at no cost as long as the supply lasts if a request is made to the Committee.

ICN AND 1949 STRUCTURE PLANS

Inquiries reaching the office of the Committee on Structure from time to time have indicated that many nurses believe further word about the attitude of the International Council of Nurses toward the "structure" plans now being considered by the profession would be forthcoming. In consequence the Executive Committee of the Committee on Structure, meeting August 10, 1949 in New York City, asked Pearl McIver, president of the ANA, which is the United States member of the ICN, for clarification. Under date of August 25, 1949, Miss McIver provided the following statement to aid nurses during their autumn discussions of organizational proposals:

> The Board of Directors of the International Council of Nurses did not consider either of the 1949 proposed plans for reorganization of professional nursing in the United States at the meeting in Stockholm in June 1949.
>
> The 1948 plan for the reorganization of professional nursing was discussed in considerable detail at the meeting of the Board in London in September 1948. The 1948 plan provided for voting of non-nurse members in the election of representatives to the House of Delegates. As was previously reported, the president of the ICN and several board members saw no objection to such a procedure since non-nurses were prohibited from becoming members of the House of Delegates or holding offices in the Association. However, some of the representatives of countries where nursing is not so strong as it is in the United States feared that such a provision in the American association might make it difficult for them to prevent certain aggressive non-nurse groups from gaining control of nursing in their countries. Therefore, the problem was referred to the membership committee of the ICN for recommendations. Since the 1948 plan was replaced by the 1949 plans I and II, and neither of those plans permits non-nurse members to vote for representatives to the House of Delegates (which is the governing

body), there seems to be no reason why it would be necessary for the ICN Board to pass on either of the 1949 plans. Both clearly provide for 'self-government by nurses in their association.'*

In Article II of the Constitution of the ICN, under 'objects,' we read:

"The International Council of Nurses stands for self-government by nurses in their associations for the purpose of raising the standards of professional education and practice, as well as those governing the ethical conduct and public usefulness of nurses."

Under membership requirements in Section 2, Article 1, of the By-laws, the requirements for active members are defined as follows:

"One national association from each country, composed of nurses or a national federation of nurses, may become an active member of the International Council of Nurses, provided its Constitution and By-Laws are in harmony with those of the International Council of Nurses and it has been accepted into membership by a majority vote of the members of the Grand Council."

Please note that the several *national associations* are the active members and that the By-Laws make no provision for individual nurse members except under Honorary membership. Ex-presidents of the ICN or "other nurses who have rendered valuable assistance to the nursing profession" may be elected Honorary members, on an individual basis.

If the governing body of a national association is made up of nurses, elected by nurses, there would be no reason for rejecting or accepting either of the 1949 plans on the basis of ICN membership.

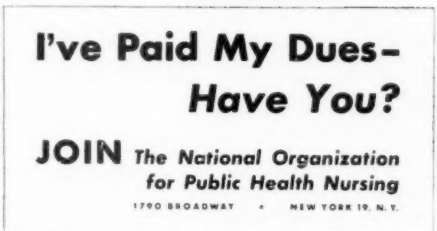
However, while the ICN constitution emphasized the importance of nurse control of the nursing association, at the meeting of the Grand Council of the ICN in Stockholm the Florence Nightingale International Foundation was accepted as a structural and functional unit of the ICN. The FNIF will retain its "Trust Deed" (which is equivalent to the Articles of Incorporation of an American association) and will have non-nurse members on its governing body. Therefore, the ICN has in its own organization made provision for non-nurse participation in one of its constituent units.

STAFF CHANGES

Mary L. Foster has joined the staff of NOPHN on a part-time basis to work on the formulation of a statement of recommended qualifications and functions of mental hygiene and psychiatric nursing personnel. This work will be done in cooperation with a psychiatric nursing consultant from the National League of Nursing Education. Funds for the project have been granted by the National Institute for Mental Health of the Public Health Service, Federal Security Agency.

Miss Foster is widely known for her work during the war 1943 to 1945 as director of the Clearing Bureau and recruitment secretary of the National Nursing Council for War Service. From 1938 to 1943 she was on the staff of the VNS of New York; from 1945 to 1948, assistant professor of nursing, Wayne University, Detroit; since January 1949, mental hygiene consultant, Kips Bay Project, New York City Department of Health. Her professional training includes in addition to basic nursing at Massachusetts General Hospital, a B.S. from Simmons College, a graduate degree from Teachers College, Columbia, in personnel and guidance, and a diploma in psychiatric nursing.

The resignation of Mary T. Collins as executive secretary of the Committee of ANA and NOPHN on Nursing in Medical Care Plans



Just off the press is this new NOPHN membership poster, with attractive Ellen Donnelly of the Brooklyn VNA waving a check to remind us to "join up" now. Printed in rust and dark blue, the poster is 12 x 18 inches in size. It is available for use at state and local meetings and may be obtained by writing to the NOPHN Membership Secretary, 1790 Broadway, New York 19. Please include a note of where and how the poster is to be used with each request.

* EDITOR'S NOTE: This is a discussion of 1949 Plan I and Plan II-A, both professional membership organizations. Plan II-B provides for a Board of Directors and Membership Body in which non-nurse members and agency and school members have a vote.

took effect August 31, 1949. Miss Collins will teach Public Health Nursing at Boston College. Her friends both at Headquarters and throughout the country regret her going, and wish her happiness and success in her new position.

100 PERCENT BOARD MEMBERSHIP

In addition to a long list of public health nursing agencies with 100% staff membership in the NOPHN, we are especially pleased also to publish the names of three agencies whose Directors are all individually enrolled as 1949 members of the National Organization. Are there other Boards to be listed? Please let us know—and we want to hear about other agencies with 100% staff membership, too.

MASSACHUSETTS
Cambridge—Visiting Nursing Association

MICHIGAN
Detroit—Visiting Nurse Association
Grand Rapids—Community Health Service

100% STAFF MEMBERSHIP

ILLINOIS
Evanston—Visiting Nurse Association

IOWA
Allamakee County Nursing Service
Des Moines—Division of Public Health Nursing, State Department of Health
Hamilton County Nursing Service
Hancock County Nursing Service
Hardin County Nursing Service
Marion County Nursing Service
Scott County Nursing Service
Tama County Nursing Service
Wayne County Nursing Service
Webster County Nursing Service

KANSAS
Kansas City—Visiting Nurse Association

MASSACHUSETTS
Hingham—Visiting Nurse & Community Service, Inc.

MICHIGAN
Ann Arbor—Mercy Hospital School of Nursing Rapid Treatment Center
Battle Creek—Practical Nurse Training Center
Charlotte—Eaton County Health Department
Flint—Vocational Rehabilitation Center
Howell—Community Nursing Service
Lansing—Michigan Nursing Center Association
Marquette—Practical Nurse Training Center Northern Michigan Children's Clinic
Muskegon—Schools of Nursing—Hackley and Mercy Hospitals
St. Clair—Community Nursing Service
St. Joseph—Berrien County Chapter, American Cancer Society
Standish—District Health Department No. 7
Traverse City—Practical Nurse Training Center

NEW YORK
Manhasset—Health Center
New York City—Judson Health Center

PENNSYLVANIA
Emmaus—Community Nursing Association

BONUS TO NEW 1950 MEMBERS

A bonus of up to three months extra membership privileges will be given all new 1950 members of the NOPHN who pay their membership dues before the first of the year. Every new member joining for 1950 between October 1 and the end of 1949 immediately becomes an active member and receives all membership privileges from date of joining through December 31, 1950.

This is not a new policy with the organization but we want to be sure that everyone knows about it. If you are not already a member of the National Organization, you are urged to join now for 1950. Membership benefits will begin at once. These include consultation and information service; free reprints; free copies *Phn*, the NOPHN quarterly news bulletin; loan folders service; use of the National Health Library; and the privilege of subscribing to PUBLIC HEALTH NURSING magazine at the special reduced rate of $3 per year.

Applications for 1950 membership and dues ($5 per calendar year, or $8 combined with one year's subscription to PUBLIC HEALTH NURSING) should be sent to NOPHN at 1790 Broadway, New York 19, See form, page A7.

BIENNIAL ROOM APPLICATION FORMS READY

Application forms to be used in securing individual hotel accommodations for the 1950 Biennial, San Francisco, May 8-12, will soon be shipped to district and SNA offices, and to NOPHN and League headquarters from which they can be obtained upon request. The Housing Committee lists hotels and their rates but points out that single rooms are limited in number, and that those planning to attend the Biennial should arrange to share twin-bed rooms or suites. Requests must be accompanied by a deposit check of $5 per person or $10 per room drawn to the account of the "1950 Biennial Nursing Convention Housing Bureau." The deposit will hold the room for the individual's day of arrival and be credited to her account. The names and addresses of all persons who will occupy rooms are to be included with the application.

LATEST REPRINTS

The following articles have recently been reprinted from the July and August issues of

PUBLIC HEALTH NURSING:—"Shall We Teach Them All To Fly" by Mary Ella Chayer (10 cents), "Cost of Living: A Decade of Changes and Trends" by Franklin B. Caffee (15 cents), and "Nurse in the School Health Program" (10 cents.) One copy is free to NOPHN members.

REMINDERS FROM THE RECORDS COMMITTEE

The Records Committee points out that the School Health Service Daily-Monthly Report (NOPHN 75) could be used to advantage in more school nursing services, both those connected with generalized agencies and those connected with boards of education. The record provides for securing statistical count of needed items, and even more important, for narrative reports concerning essential aspects in school nursing as practiced today. Get a sample copy with instructions from Mead and Wheeler, 1022 South Wabash Avenue, Chicago 5, Illinois.

The NOPHN Records Committee has decided that the Labor and Delivery Record (NOPHN 74) need no longer be printed and sold by Mead and Wheeler. Comparatively few agencies are offering delivery service and the current sales do not justify keeping the record in stock.

NOPHN FIELD SCHEDULE

Staff Member	*Place and Date*
Anna Fillmore	New Haven, Conn.—Oct. 19
Lucy E. Blair	Richmond, Norfolk, and Charlottesville, Va.—Oct. 10-23
Ruth Fisher	Richmond, Va.—Oct. 17
	New Haven, Conn.—Oct. 19
Marion P. Kerr	Toronto, Can.—Oct. 15-29
Louise M. Suchomel	
Dorothy Rusby	Brooklyn, N. Y.—Oct. 3-14
Jean South	Washington, D. C.—Oct. 10, 11
Marie Swanson	Chicago, Ill.—Oct. 6
	Highland Park, Ill.—Oct. 13-15

ABOUT PEOPLE WE KNOW

Patricia I. Heely has been named director of the Bureau of Public Health Nursing, New York City Department of health. . . . *Mary Lee Brown* has recently been awarded a fellowship for advanced study in Europe by the Commonwealth Fund. She sailed September 21 for London where she will study the social aspects of the Medical Care Program in Great Britain, under the direction of the London School of Hygiene and Tropical Medicine. . . . *Vera P. Hansel* has assumed the responsibilities of regional public health nursing consultant with USPHS, San Francisco office. Mrs. Hansel replaces *Alice Rorrison Fisher* who resigned to move to Seattle. . . . *Lillian A. Gardiner,* senior nurse officer, PHS, is the newly appointed regional public health nursing consultant for the six New England states. . . . *Lita Korbe* assumed her duties as director of public health nursing, Montana State Board of Health, effective August 15. . . . *Evelyn Kidneigh* is the new state director of public health nursing in Utah. . . .*Anna Amann* has been appointed director of the Bureau of Public Health Nursing, New Orleans Health Department, succeeding *Christine Causey* who has accepted a temporary position as executive secretary of the Louisiana SNA. . . . We have received notification of the following appointments to positions in public health nursing in California: *Eleanor Wood,* supervising nurse, San Joaquin Local Health District, Stockton, *Margaret Bernard,* director of nurses in Vallejo-Solano County Health Department, and *Leah Barskey,* supervising nurse, Vallejo-Solano County Health Department, Vallejo. . . *Norma Whiteside* and *Bernice Hotchkiss* have joined the staff of the California Department of Public Health as nursing consultants.

Notice of appointments of three members to the staff of the Office of Public Health Nursing, Department of Public Health, Pittsburgh has been received: *Jeannette Rosenstock,* assistant chief in administration; *Wilda Camery,* assistant chief in education; and *Alice Wooldridge,* public health nursing supervisor. . . From the Frances Payne Bolton School of Nursing, Western Reserve University comes the following: *Verna L. Huge,* formerly of the Territorial Department of Health, Juneau, Alaska, has been appointed field instructor in public health nursing. *Annabel Griffith,* field instructor in public health nursing since 1944, is now assistant professor and director of the University Public Health Nursing District in Cleveland.

NEWS AND VIEWS

RECRUITMENT PICTURE LOOKS UP

Recruitment for fall classes is finished or is rapidly drawing to a close in many areas. A survey made July 15 by NLNE's Department of Studies shows considerable improvement over a year ago:

Year	Schools Reporting	Applications Accepted	Applications Pending	Total
1949	1005	23,374	12,299	35,673
1948	1056	21,963	11,826	33,789

In a recent letter to state organizations and schools, Theresa I. Lynch, secretary of the Committee on Careers in Nursing, pointed out that it is time to get fall recruitment plans under way. She also listed recruitment materials being prepared by local groups, and leaflets and posters available for purchase.

"Careers in Nursing" books have been prepared by Detroit's Committee on Careers for the use of high school counselors. These are loose-leaf notebooks containing information on types of schools of nursing (professional and practical), academic and personal qualifications, how to select a school, how to apply, cost of nursing education, scholarships, employment opportunities, and other pertinent information.

The American Hospital Association is offering, at reduced prices, the special 4-color leaflet prepared for the 1948 campaign for use as a mailing piece or on bulletin boards. Cost is $4 for 100. The 1948 poster, "Nursing—The Career You Are Seeking," may also be purchased, 10 for $1. Send orders to AHA, 18 E. Division Street, Chicago 10, Illinois.

"Selling Nursing Short," reprint of an article dealing with the correspondence schools for practical nursing and the danger "graduates" of such schools can cause, is available from the Committee on Careers at 3 cents each.

RED CROSS AND THE SERVICEMAN

There are 1,600,000 men and women in our peacetime military establishment. The American Red Cross is the one agency which acts to strengthen the morale of servicemen as well as to relieve anxieties of the folks back home. At the Red Cross convention recently Defense Secretary Louis Johnson told his audience that "We of the National Military Establishment need the work of the Red Cross as we need a good right arm."

Direct Red Cross aid to the serviceman and his family is carried out by three services closely related and dependent on each other. These are: (1) Military Welfare Service, dealing principally with servicemen in camps, posts, and stations around the world (2) Service in Military Hospitals, dealing principally with the sick and injured and (3) Home Service, through 3746 Red Cross chapters handling the family end of the serviceman's problem.

IMPROVING THE COMICS

The National Social Welfare Assembly initiated recently a new, experimental venture seeking to bring to American youth socially constructive information and ideas and to encourage better publication in the comics field. The plan has been worked out in collaboration with National Comics Publications, and will serve a dual function.

The first of the public service messages will appear in August in 32 comic magazines with an estimated circulation of 10,000,000. It carries a "back-to-school" theme, stressing the importance of continuing education as a sound investment for the future. Other messages scheduled for later publication are "Give Your Town a Present," urging young people to volunteer for civic activities, in October; a page on health, in November; a page devoted to brotherhood and the importance of combating prejudice, in December. For January, there is a message stressing the importance of curbing vandalism, and in February the brotherhood theme will be re-

peated to coincide with National Brotherhood Week.

● The Lectures to the Laity, open to the public, at the New York Academy of Medicine, will interest all nurses. They include Franz Alexander, M.D., "Frontiers in Psychiatry", September 28; David Seegal, M.D., "Methuselah—Myth or Promise", October 26; Laurence H. Snyder, "Frontiers in Genetics", November 16; John H. Gibbon, Jr., M.D., "Machines That Work Like Men", December 7; Selman A. Waksman, "The Biology of the Antibiotics", January 11; and Thomas M. Rivers, M.D., "Concepts and Methods of Medical Research", January 25. The time is 8:30 p.m.

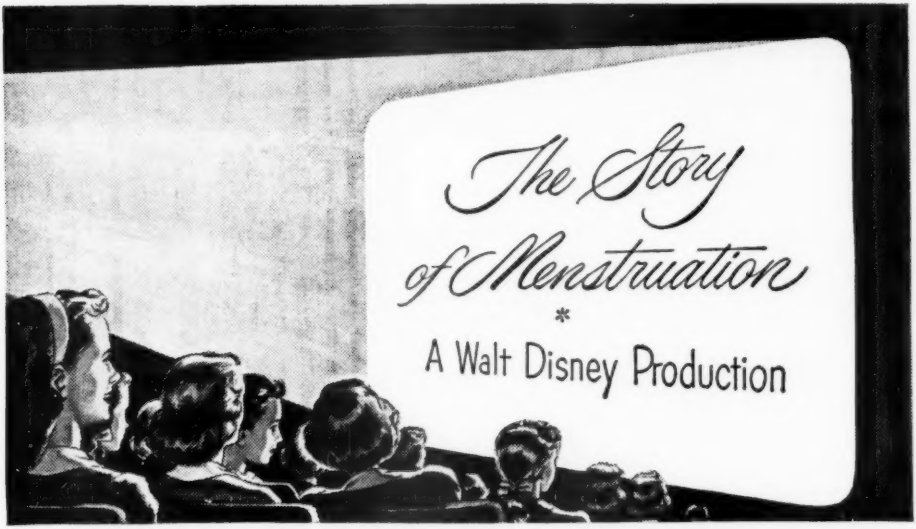
● The University of Cincinnati, College of Nursing and Health, beginning with the fall semester, is offering supplementary and advanced programs for graduate nurses. Program A is designed for the graduate of the three-year basic diploma program who wishes to supplement her preparation to make it comparable to that of the graduate of a basic collegiate program. Program B is for the graduate of the basic program who has a background of experience in nursing and wishes to prepare for teaching and supervision in clinical nursing.

● The American Association for Health, Physical Education, and Recreation has instituted an exchange placement service for health educators, physical educators, and recreation leaders. Applicants for such positions are urged to complete four copies of a card listing name, age, present occupation, and college training, as well as specific training and experience. Three of these cards will be sent to prospective employers for examination, the fourth will be kept at the National Office. Employers, too, are urged to submit a card stating general qualifications for positions to be filled. For further information write to the Association at 1201 16th Street NW, Washington 6, D. C.

● The 37th annual convention of the National Safety Council will be held in Chicago, October 24-28, 1949.

● The National Society for Crippled Children and Adults will hold its annual convention at the Hotel Commodore, New York City, November 7-10, 1949. Highlight of the occasion will be the President's Banquet on Tuesday night, and the Wednesday luncheon at which Dr. William Menninger will speak.

● The 34th annual conference of the New England Industrial Nurses Association will be held in Providence, Rhode Island, October 15-16, 1949.



10,000 Mothers agree—

"My daughter should see this film"

Available, free, on short-term loan!

A recent magazine article explained this movie to readers throughout the country. Over 10,000 parents wrote voluntarily that they wanted their girls to see it!

The "Story of Menstruation" is indeed a generation ahead. Tells young students much they need to know about this normal bodily function. Straightforward, yet completely dignified.

*T. M. REG. U. S. PAT. OFF.

Be sure every student sees it! A 16 mm. full color sound print is yours on request.

SIMPLY MAIL THE COUPON BELOW: ⬇

Educational Dept. PHN-109
International Cellucotton Products Co.,
919 N. Michigan Ave., Chicago 11, Ill.

Please send me, free, with the compliments of Kotex*, the following material:

- ☐ Full details on the movie, "The Story of Menstruation."
- ☐ Copies of the student booklet "Very Personally Yours."
- ☐ One full color, jumbo-size Menstrual Physiology Chart.
- ☐ One Teacher's Guide.

Name.....

Title or Position.....

Address.....

City.....*State*.....

The Importance of Meat To Your Geriatric Patients

That a significant number of elderly persons suffer from a deficiency of protein, iron, B complex vitamins, and calcium is the consensus of most geriatrists. Depending upon the extent and duration of these nutrient deficits the well-being and stamina of the individual are undermined, not infrequently to the point where the presence of organic disease may be suspected. Furthermore, nutrient deficiencies of long standing lower resistance to infectious disease and appreciably increase the hazards of surgery.

Thorough evaluation of the dietary of aged patients with particular emphasis on protein, iron, B complex vitamins and calcium, and institution of indicated adjustments in dietary habits can produce results gratifying to both patient and physician. Meat, an important source of biologically complete protein, iron, and B complex vitamins, has earned a deserved position in the dietary of elderly persons as well as in the dietary of younger individuals. Rarely contraindicated even in the presence of cardiovascular or renal disease, meat leads to virtually no alimentary difficulties since the more tender cuts are digested with particular ease. In the presence of mastication impairment ground meat may be employed. A serving or two of meat daily in the dietary of the aged goes far in preventing nutrient deficiencies and can contribute significantly to health and well-being.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

American Meat Institute

Main Office, Chicago...Members Throughout the United States

The best way to deal with LICE

Just Specify EASIER-TO-APPLY *A-200* PYRINATE LIQUID

When you encounter cases of lice infestation, there is one way to dispose of the problem quickly and surely. Specify the scientifically developed formula, A-200 Pyrinate Liquid, superior on several counts—

A. A-200 is a sure, fast killer of lice, and their eggs . . . on contact. One 15-minute application is usually sufficient.

B. A-200 is non-poisonous, non-irritating, and leaves no tell-tale odor.

C. A-200 is easy to use. It is a liquid . . . no greasy salve to stain clothing. Especially recommended for children. At your drugstore, only 79¢.

Send for a supply of the leaflet addressed to parents, telling them in diplomatic, sympathetic language the dangers of pediculosis. It is appreciated by mothers for its helpful, informative contents.

McKesson & Robbins, Inc., Bridgeport, Conn.
Famous for quality since 1833

McKesson & Robbins, Inc.
Bridgeport, Conn.

Please send me a supply of the leaflet, "Pediculosis Capitis is *dangerous.*"

Name_____

Street_____

City_____ Zone____ State_____

Pupil for a day

One morning last Spring when the school bell rang in a school in Wisconsin, mothers (and even some fathers) flocked in with their children for a unique kind of instruction. Local and state health experts took over classrooms and auditorium to teach good food habits.

The parents were brought face to face with a three-day survey of their children that revealed startling diet deficiencies. Hardly the result of scarcities—since most of the foods were grown right in the locality—these diet deficiencies were caused by poor food habits. Charts vividly pictured for the parents how the inclusion of each of the basic 7 food groups contributed to a child's good health.

A great deal of information had to be packed into one day's program, but when school was out, all went home convinced that one way to solve urgent health problems was through the co-operation of home, school and health agencies. A few hours of direct contact with the parents had accomplished more than months of indirect contact through the children.

For further information on conducting a similar Parents' Day in your school or for materials and individual guidance on your nutrition projects, make it a point to write General Mills today. Our "Program of Assistance in Nutrition and Health Education" is prepared in manifold ways to help make your projects a success.

SUGGESTED PROGRAM FOR A PARENTS' DAY

Morning:

Discussion held in classrooms on results of a diet survey taken in preparation for Parents' Day.

Lectures by local or other health authorities on health problems.

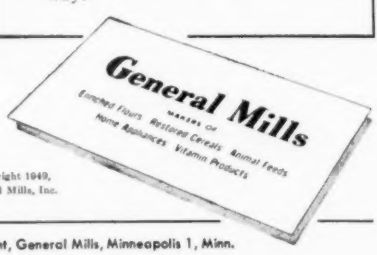
Noon:

Model meal served parents in school lunchroom.

Afternoon:

Educational movies on nutrition and health.

Visiting classrooms to examine nutrition and health projects under way.



ADDRESS LETTERS to the Education Section, Public Services Department, General Mills, Minneapolis 1, Minn.

NEW! DIFFERENT!
AND SO CONVENIENT!

THE NEW

Measure-Pak

EASY MEASURING GUIDE

1 print = ½ CUP
½ print = ¼ CUP
¼ print = 2 TABLESPOONS

Every pound is cut in quarters to make measuring easy . . . cooking breezy!

Here's the most welcome margarine news of the year! Nucoa is in the wonderfully convenient new Measure-Pak—designed to do away with slow, bothersome spoon-and-cup measuring for good. Just use Nucoa quarters as a scale—and get the exact amount your recipe calls for . . . easily, speedily, accurately. Handy new Measure-Pak is another Nucoa "first"—latest of the many reasons why home economists and housewives alike have trusted Nucoa for over 30 years.

EASIER TO "BOWL-MIX" TOO! You don't have to soften a *solid* pound block before you start coloring . . . it reaches the right mixing temperature more quickly and evenly . . . and it's easier to distribute the pure color wafer evenly, right at the start. Enriched with 15,000 units of Vitamin A per pound, delicious, churn-fresh, Nucoa margarine is as fine a spread for bread as you can buy.

ONLY NUCOA—AMERICA'S LARGEST-SELLING MARGARINE

—NOW IN THE NEW Measure-Pak

POSITIONS AVAILABLE

WANTED—Supervisor of public health nurses for County Health Department with generalized public health nursing program including three Crippled Children's Clinics and five Otological Clinics each year. Three weeks study leave every other year, fifteen days vacation and twelve days sick leave allowed for each year. State Retirement System. *Qualifications:* Bachelor's degree, Public Health Nursing credential with course of eight months in supervisoral training and at least one year's experience in public health nursing on a generalized public health program. Opening salary $300. with increases to $329. Must own car. 8c per mile for mileage allowed. Apply Health Officer, Dept. of Public Health, 842 Front Street, Santa Cruz, California.

WANTED—Public health nursing supervisor for voluntary agency . . . congenial eight nurse staff. Minimum requirements—completion of approved program of study in public health nursing; experience in a visiting nurse association. Salary open, four weeks paid vacation annually, also two weeks sick leave. Car necessary. Write Miss Mary Luvisi, R.N., director, Visiting Nurse Association, 1 Broadcast Place, Jacksonville, Florida.

WANTED—Qualified public health nurse for generalized program in District Health Department. Liberal salary, adequate travel allowance, vacation, sick leave, and in-service training program. Write: District Health Department, Coldwater, Michigan.

WANTED—Qualified public health nurse for staff position in private (two nurse) agency integrated with County Health Department. Car furnished. Beginning salary $2940. Retirement plan. Apply: Manhasset Health Center, 2355 Northern Blvd., Manhasset, L. I., N. Y

WANTED—Public health nurses to fill vacancies in health department. Generalized service including maternal and child care, school health and communicable disease control. Immediate appointment on provisional basis. Salary range $2520-$2880. Vacation allowance; sick leave; in-service training. Write: Director of Public Health Nursing, State Board of Health, State Health Building, Little Rock, Arkansas.

WANTED—Qualified orthopedic nursing supervisor; preferably with public health nursing experience and preparation, for crippled children's department in a state institution. Duties include orthopedic nursing consultant service to state staff of 35 public health nurses. Merit system. Beginning salary $3,140. Apply: Executive Secretary, Delaware State Board of Health, Dover, Delaware.

WANTED—Three qualified public health staff nurses Starting salary $2,921.50. Car furnished or allowance; 5 day week. Inservice training. Newly revised generalized program. Opportunity to work under highly qualified supervision. Write: Chairman, Board of Health, City Hall, La Crosse, Wisconsin.

WANTED—Well qualified Public Health Nurses to work in a new Bi-County Health Department planning a field training program. Present salary range $2,940-$3,060. To be increased as soon as training program is established. Car allowance $600 a year. Vacation one month. Reply: Dale E. Sholz, M.D., Lawrence-Wabash County Health Department, Lawrenceville, Illinois.

HOPKINS
NOPHN STYLE
UNIFORMS

Unexcelled!

TO ORDER . . . Give style number, height, weight, dress size, hat size. Enclose $20.00 deposit on suit or coat order, $2.00 dress or cap order. Balance C.O.D.

055D—Double-breasted Box Coat
044S—Single-breasted Box Coat
022G—Double-breasted Fitted Coat

All three are not only rainproofed and fully lined with Skinner's "Sunbak" satin, but are "Boconized" — guaranteed 5 yrs. mothproof. Choice of fabric—Elastique, (heavy weight) or Whipcord (medium weight) Stock sizes 10 to 46 — regulars, shorts, longs. **$60.00**

Custom-tailored, if necessary—10% extra. Sleeveless red wool zippered-in-lining. $10.00
(can be ordered at any time)

Beret—**$4.50**; Overseas Cap—**$3.50**

N-3 Navy Blue Nylon Dress **$13.50**
S-2 Cramerton Seersucker Dress ..... **$ 8.45**
(Beret—$2.25; Overseas Cap—$1.75)
P-1 Simpson's Soulette Poplin ..... **$ 8.45**

01GS Navy Blue Gabardine Suit **$45.00**
All wool and "Boconized" (mothproof.) Stock sizes 10 to 46. Regulars, shorts, longs.
Custom-tailored 10% extra. Extra skirt $17.50

HOPKINS TAILORING CO., 107 W. FAYETTE ST., BALTIMORE 1, MD.

Smart NOPHN *Twosome*

Double-Breasted

WINTER BOXCOAT
With Zip-In Lining

NOPHN Style 485 is a magnificent "lifetime" coat. Made of Navy Blue All Wool Elastique outer material and mothproofed by Bocanize Process. Fully lined with Skinner's satin-faced wool-back lining. Convertible collar. Complete All Wool Flannel detachable zip-in lining with famous Talon zipper. Sizes 32-46.

Specially Priced at $67.50
(including zip-in lining)

NOPHN Style 480 is superb for Fall and Spring. Same as Style 485, without the zip-in lining. Sizes 32-46.

Only $57.50

NOPHN Style 04
- Matching All-Wool Cap
- Small, Medium, Large $3.50

ORDER NOW
Immediate Delivery

Year 'Round Uniform in
NAVY BLUE BROADCLOTH

NOPHN Style 666B Broadcloth is silky-soft, unexcelled for wearability. Made of luxurious combed all-pima yarn and sanforized to ensure perfect fit. Extraordinary value. Sizes: 10-20, 40-46.

Only $9.95

Also Available in:
POPLIN Style 666-P ..... $ 7.95
NYLON Style 666-N $12.95

VISIT OUR SHOPS

NEW YORK
PITTSBURGH
DETROIT
CHICAGO
BALTIMORE

BRUCK'S

Mail Orders To:

Dept. PH-10
387 Fourth Avenue
New York 16, N. Y.

——ASK FOR FREE CATALOG——